Commonwealth of Massachusetts

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services

Recommendations of the Special Commission on Provider Price Reform

Appendices

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendices

Presentations to the Special Commission

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Recommendations of the Special Commission on Provider Price Reform

Appendix A

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix A:

Section 67 of Chapter 288 of the Acts of 2010: *An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses.*

SECTION 67:

(a) Notwithstanding any general or special law to the contrary, there shall be a special commission on provider price reform that shall investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers. The commission shall examine policies aimed at enhancing competition, fairness and cost-effectiveness in the health care market though the reduction of reimbursement disparities. Any recommendations shall consider, and be consistent with, the recommendations of the special commission on payment system as authorized in section 44 of chapter 305 of the acts of 2008.

(b) The commission shall consist of the secretary of administration and finance and the commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, and 5 members to be appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and 1 of whom shall be a health economist or expert in the area of payment methodology. The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. No action of the commission shall be considered official unless approved by a majority vote of the commission members.

(c) The commission shall examine: (i) the variation in relative prices paid to providers within similar provider groups; (ii) the variation in costs of providers for services of comparable acuity, quality and complexity; (iii) the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses; (iv) the correlation between price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payor mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs; (iii) the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and (v) policies to promote the use of providers with low health status adjusted total medical expenses.

(d) In making its investigation, the commission shall consult with the attorney general, the health care quality and cost council, the division of health care finance and policy, health care economists, and other individuals or organizations with expertise in state and federal health care payment methodologies and reforms. The commission shall use data and recommendations gathered in the course of these consultations as a basis for its findings and recommendations.

(e) The commission shall file a report of its findings and recommendations.
Before a final vote on any recommendations, the commission shall consult with a reasonable variety of parties likely to be affected by its recommendations, including, but not limited to, the office of Medicaid, the division of health care finance and policy, the commonwealth health insurance connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers. The commission shall file the report of its findings and recommendations, with the clerks of the senate and the house of representatives and with the governor not later than September 30, 2011.

Commonwealth of Massachusetts

Deval L. Patrick
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Recommendations of the Special Commission on Provider Price Reform

Appendix B

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix B:

Special Commission Meeting Agendas

Special Commission on Provider Price Reform

June 20, 2011 Meeting #1

10:00 a.m. – 1:00 p.m.

John Daley Room, 5th Floor, 2 Boylston Street
Boston, MA 02116

Agenda

I. Welcome

II. Introduction of Special Commission Members
   a. Introduction of consultant

III. Special Commission's Role and Responsibilities
   a. Overview of statute (Section 67 of Chapter 288 of the Acts of 2010)
   b. Process and expectations

IV. Review of Recommendations by the Special Commission on the Health Care Payment System

V. Principles for Provider Price Reform

Break

VI. Proposed Work Plan
   a. Timeline and scheduled activities
   b. Stakeholder engagement process

VII. Next Steps
   a. Schedule of upcoming meetings

Special Commission on Provider Price Reform

July 13, 2011 Meeting #2

9:00 a.m. – 1:00 p.m.

John Daley Room, 5th Floor, 2 Boylston Street
Boston, MA 02116

Agenda

I. Welcome

II. Special Commission on Provider Price Reform: Review of Objective and Scope

III. Review of Stakeholder Feedback

IV. Continued Discussion of Principles for Provider Price Reform

V. Background on the Massachusetts Health Care Landscape

VI. Findings from Attorney General's Examinations of Health Care Cost Trends and Cost Drivers Pursuant to G.L.c. 118G, § 6½(b)

VII. Provider Price Variation Analyses

VIII. Next Steps

Special Commission on Provider Price Reform

July 29, 2011 Meeting #3

9:00 a.m. – 1:00 p.m.

John Daley Room, 5th Floor, 2 Boylston Street
Boston, MA 02116

Agenda

I. Welcome

II. Review of Additional Stakeholder Feedback

III. Review of Revised Provider Price Reform Principles

IV. Review of Analytic Findings and Additional Analyses

V. Recommendations of the Office of the Attorney General

VI. Potential Strategies to Reduce Disparities in Payment Rates

VII. Recent Proposals to Address Price Variation

VIII. Next Steps

Special Commission on Provider Price Reform

August 15, 2011 Meeting #4

10:00 a.m. – 1:00 p.m.

John Daley Room, 5th Floor, 2 Boylston Street
Boston, MA 02116

Agenda

I. Welcome

II. Review of Revised Principles for Provider Price Reform

III. Discussion of Potential Strategies to Reduce Disparities in Payment Rates

IV. Next Steps

Special Commission on Provider Price Reform

August 17, 2011 Meeting #5

10:00 a.m. – 1:00 p.m.

John Daley Room, 5th Floor, 2 Boylston Street
Boston, MA 02116

Agenda

I. Welcome

II. Review of Stakeholder Feedback

III. Discussion of Potential Strategies to Reduce Disparities in Payment Rates

IV. Next Steps

Special Commission on Provider Price Reform

September 21, 2011 Meeting #6

10:00am-1:00pm

2 Boylston Street, 5th Floor, Boston, MA

Agenda

I. Welcome

II. Review of Stakeholder Feedback

III. Presentation and Consideration of Four Options

IV. Report Development and Written Recommendations

V. Meeting Summary and Conclusion

Special Commission on Provider Price Reform

November 9, 2011 Meeting #7

9:00am-12:00pm

2 Boylston Street, 5th Floor, Boston, MA

Agenda

I. Welcome

II. Discussion of Recommendations and Report

III. Commission Vote

IV. Meeting Summary and Conclusion

Commonwealth of Massachusetts

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services

Recommendations of the Special Commission on Provider Price Reform

Appendix C

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix C:

Presentations to the Special Commission

C.1: Special Commission on Provider Price Reform: June 20, 2011

C.2: Special Commission on Provider Price Reform: July 13, 2011

C.3: Findings from Attorney General's Examinations of Health Care Cost Trends and Cost Drivers

C.4: Testimony of Panelists from 2011 Health Care Cost Trends Hearings- Price Variation in Massachusetts Health Services

C.5: 2011 Health Care Cost Trends Hearings: Prefiled Testimony from Certain Payers and Providers Related to Price Variation

C.6: Recommendations from Attorney General's Examination of Health Care Cost Trends and Cost Drivers

C.7: Special Commission on Provider Price Reform: July 29, 2011

C.8: Special Commission on Provider Price Reform: August 15, 2011

C.9: Special Commission on Provider Price Reform: August 17, 2011

C.10: Special Commission on Provider Price Reform: September 21, 2011

Special Commission on Provider Price Reform

June 20, 2011

10:00 a.m. – 1:00 p.m.

2 Boylston Street, Boston, MA 02116

Agenda

- Introduction of Special Commission members
- Special Commission's roles and responsibilities
- Review of recommendations by the Special Commission on the Health Care Payment System
- Proposed work plan
- Principles of provider price reform
- Next steps: Schedule of upcoming meetings

Membership of Special Commission

***Ex-Officio* Members**	
Jay Gonzalez	Secretary, Executive Office for Administration and Finance (co-chair)
Seena Perumal Carrington	Acting Commissioner, Division of Health Care Finance and Policy (co-chair)
Dolores Mitchell	Executive Director, Group Insurance Commission
Legislative Appointments	
Richard T. Moore *Appointee of the Senate President*	Senator, Massachusetts State Senate Senate Chair of Joint Committee on Health Care Financing
Steven M. Walsh *Appointee of the Speaker of the House*	Representative, Massachusetts House of Representatives House Chair of Joint Committee on Health Care Financing
Gubernatorial Appointments	
Amitabh Chandra, PhD *Representing a health economist or expert in the area of payment methodology*	Economist and Professor of Public Policy, Harvard Kennedy School of Government
Patrick Gilligan *Representing Blue Cross and Blue Shield of Massachusetts, Inc.*	Senior Vice President for Health Care Services, Blue Cross Blue Shield of Massachusetts
H. Eugene Lindsey, MD *Representing the Massachusetts Medical Society*	President and CEO, Atrius Health
Eric Linzer *Representing the Massachusetts Association of Health Plans, Inc.*	Senior Vice President, Massachusetts Association of Health Plans
Lynn Nicholas, FACHE *Representing the Massachusetts Hospital Association, Inc.*	President and CEO, Massachusetts Hospital Association

Overview of Statute

- The Special Commission on Provider Price Reform was created under Section 67 of Chapter 288 of the Acts of 2010.

- Goal: Investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers.

Overview of Statute

- The Special Commission will examine policies aimed at enhancing competition, fairness, and cost-effectiveness in the health care market *through the reduction of reimbursement disparities*.
- The Special Commission shall develop recommendations that will consider, and be consistent with, the recommendations of the Special Commission on the Health Care Payment System, as created under Section 44 of Chapter 305 of the Acts of 2008.

Responsibilities

The Special Commission shall examine:

- The variation in relative prices paid to providers within similar provider groups
- The variation in costs of providers for services of comparable acuity, quality, and complexity
- The variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses
- The correlation between the price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payer mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs
- The correlation between the price paid to providers and status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital
- Policies to promote the use of providers with low health status adjusted total medical expenses

Outcome

The Special Commission shall file a report of its findings and recommendations.

Required Consultations

- In making its investigation, the Special Commission is required to consult with:
  - Office of the Attorney General
  - Health Care Quality and Cost Council
  - Division of Health Care Finance and Policy
  - Health care economists
  - Other individuals or organizations with expertise in state and federal health care payment methodologies and reforms

Required Consultations

- Before a final vote on any recommendations, the Special Commission is required to consult with "a reasonable variety of parties likely to be affected by its recommendations, including, but not limited to:"
  - Office of Medicaid
  - Division of Health Care Finance and Policy
  - Commonwealth Health Insurance Connector
  - Massachusetts Council of Community Hospitals
  - Massachusetts League of Community Health Centers
  - 1 or more academic medical centers
  - 1 or more hospitals with a high proportion of public payers
  - 1 or more Taft-Hartley plans
  - 1 or more self-insured plans with membership of more than 500
  - Massachusetts Municipal Association
  - organizations representing health care consumers

Procedural Considerations

- A majority vote of the Special Commission is required before any action is considered "official."
- Special Commission meetings are subject to the state's open meeting law.
- State ethics laws:
  - Nancy Panaro, DHCFP General Counsel
  - (617) 988-3128 or nancy.panaro@state.ma.us

Review of Recommendations by the Special Commission on the Health Care Payment System

2009 Special Commission on the Health Care Payment System

- The Special Commission on the Health Care Payment System was created under Section 44 of Chapter 305 of the Acts of 2008.

- Goal: Investigate reforming and restructuring the payment system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.

Special Commission Process

The Commission met nine times between January and July 2009 to:

- Examine payment methodologies and purchasing strategies, including, but not limited to alternatives to fee-for-service models;
- Recommend a common transparent payment methodology; and
- Recommend a plan for the implementation of the common payment methodology across all public and private payers in the Commonwealth, including discussing seeking a waiver from federal Medicare rules to facilitate implementation.

Principles for Payment Reform

- As currently implemented, fee-for-service payment rewards service volume rather than outcomes and efficiency. Therefore other models should be considered.

- Health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high quality health care that aligns with evidence-based guidelines where available, and produces superior outcomes and improved health status. Performance measurement should rely on reliable information and utilize uniform, nationally accepted quality measures.

- Provider payment systems should balance payments for cognitive, preventive, behavioral, chronic and interventional care; support the development and maintenance of an adequate supply of primary care practitioners; and respond to the cross-subsidization occurring within provider organizations as a result of the current lack of balance in payment levels by service.

Principles for Payment Reform

- Differences in health care payments should reflect measurable differences in value (cost and quality). Payments should be adjusted for clinical risk and socio-economic status wherever technically possible, and should promote greater equity of payments across payers and providers, to the extent that this is financially feasible.
  - Differences in health care payments should be transparent, including across different payers.
  - Costs associated with desired investments in teaching and research should be paid outside of base payments, and should require provider accountability for how such payments are spent.
  - Costs associated with desired investment in special "stand by" capacity should be accounted for in the payment system.
- The health care payment system should be structured in such a way as to minimize provider, payer and patient administrative costs that do not add value.
- Payment reform must consider how:
  - Some payment methods may require certain organization of the service delivery system, and
  - Health benefit designs either support or limit payment reform.

Principles for Payment Reform

- Health care per capita costs and cost growth should be reduced, and providers, payers, private and public purchasers and patients should all share in the savings arising from payment reform.
- The health care payment system should be transparent so that patients, providers and purchasers understand how providers are paid and what incentives the payment system creates for providers.
- It will be necessary to consider the diversity of populations, geography, and providers across the Commonwealth when designing payment reform to ensure high quality, patient-centered care to all populations and geographic regions in the Commonwealth.
- Implementation should be phased over time with:
  - Clear and attainable deadlines;
  - Planned evaluation for intended and unintended consequences; and
  - Mid-course corrections.

Unanimous Recommendation

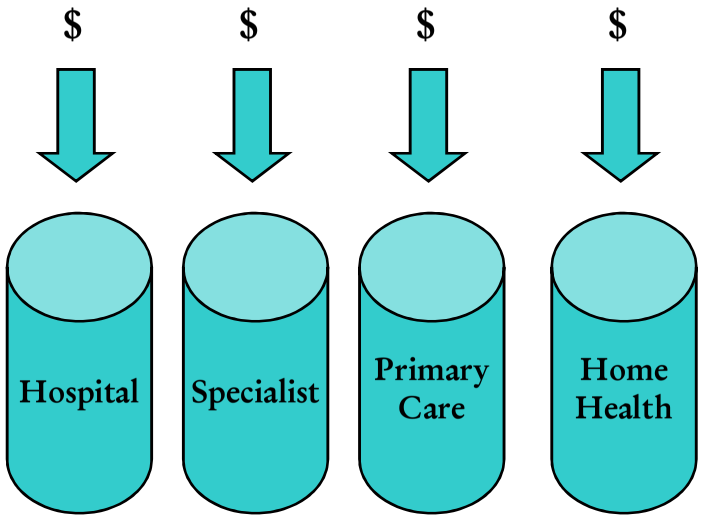
The Special Commission recommends that global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts within a period of five years.

- Government, payers and providers will be required to share responsibility for providing infrastructure, legal and technical support to providers in making this transition.

Current Fee-for-Service Payment System

The Problem

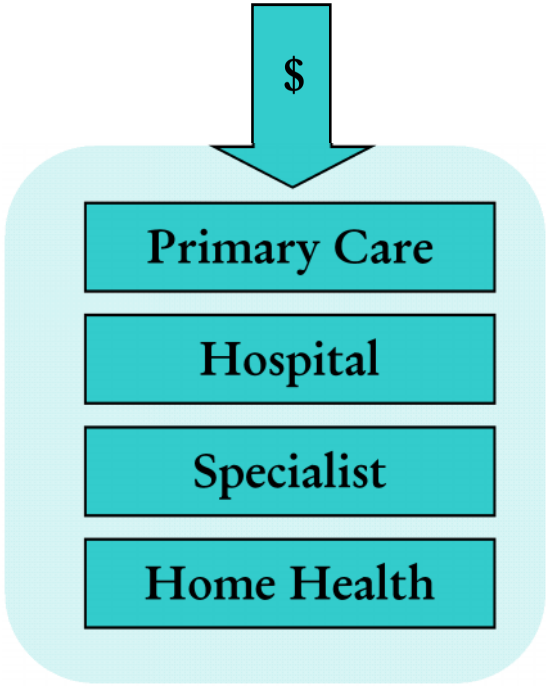
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



Patient-Centered Global Payment System

The Solution

Global payments made to a group of providers for all care. Providers are not rewarded for delivering *more* care, but for delivering the *right* care to meet patient's needs.



Key Components of Recommendations

- Participation by private and public payers
- Development of Accountable Care Organizations (ACOs)
- Patient-centered care and adoption of medical homes
- Patient choice
- Common core performance measures and cost and quality transparency
- Appropriately balanced sharing of financial risk between ACOs and carriers
- Strong and consistent risk-adjustment

Key Recommendations Related to Provider Price Variation

Among other responsibilities, an oversight entity will:

- Establish transition milestones and monitor progress, with a focus on the progress to global payments, progress to greater payment equity, and per capita health care costs.
- Set milestones for achievement of value-based payment equity and monitor market progress toward these targets. Metrics for monitoring might include:
  - variation in levels of risk-adjusted global payments to ACOs across payers;
  - variations in levels of payments to different providers within ACOs, and payments for lines of services such as primary care and behavioral health and other services.

The oversight entity will have authority to assist, intervene, and make mid-course corrections if needed.

Proposed Work Plan

Proposed Work Plan

- Timeline
- Stakeholder engagement strategy
- Meeting process
  - Data analysis and literature review
  - Consideration of provider price reform options
  - Development of recommendations and written report

Setting Our Course

- As the Special Commission starts its work, it is important to define common terminology and develop principles to guide the review of strategies to reduce the variation in provider prices

Common Terminology: Definitions

- Cost: expenses that a health care provider incurs in order to deliver a specific service or treatment (or bundle of services)
- Price: the amount of money that the health care provider has agreed to accept for a given service (or bundle of services)
- Payment: the amount of money that the health care provider receives for a given service (or bundle of services.)

Metrics Referenced in Statute

- Relative Prices
- Health Status Adjusted Total Medical Expenses
- Acuity
- Quality
- Provider costs

Principles for Provider Price Reform

- Do we agree with the base assumption of the Special Commission's legislative mandate?
  - Reduction in the variation of provider health care reimbursement will enhance competition, fairness, and the cost-effectiveness of the health care market.
- What principles should guide the development of any provider price reform recommendations?

Next Steps: Schedule of Upcoming Meetings

- July 6th (10:00 a.m. – 3:00 p.m.)
- July 18th (9:00 am – 3:00 p.m.)
- August 8th (10:00 a.m. – 1:00 p.m.)
- August 15th (10:00 a.m. – 1:00 p.m.)
- September 12th (10:00 a.m. – 1:00 p.m.)

Special Commission on Provider Price Reform

July 13, 2011

Agenda

- Special Commission on Provider Price Reform: Review of Objective and Scope
- Review of Stakeholder Feedback
- Continued Discussion of Principles for Provider Price Reform
- Background on the Massachusetts Health Care Landscape
- Findings from Attorney General's Examinations of Health Care Cost Trends and Cost Drivers Pursuant to G.L.c. 118G, § 6½(b)
- Provider Price Variation Analyses
- Next Steps

Statute Overview

Objective: Investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers.

Scope: Examine policies aimed at enhancing competition, fairness, and cost-effectiveness in the health care market *through the reduction of reimbursement disparities.*

Review of Stakeholder Feedback

- Health Care For All and other consumer advocates
- Massachusetts Hospital Association
- Massachusetts League of Community Health Centers
- Massachusetts Coalition of Nurse Practitioners
- Massachusetts Association of Health Plans

Review of Draft Principles

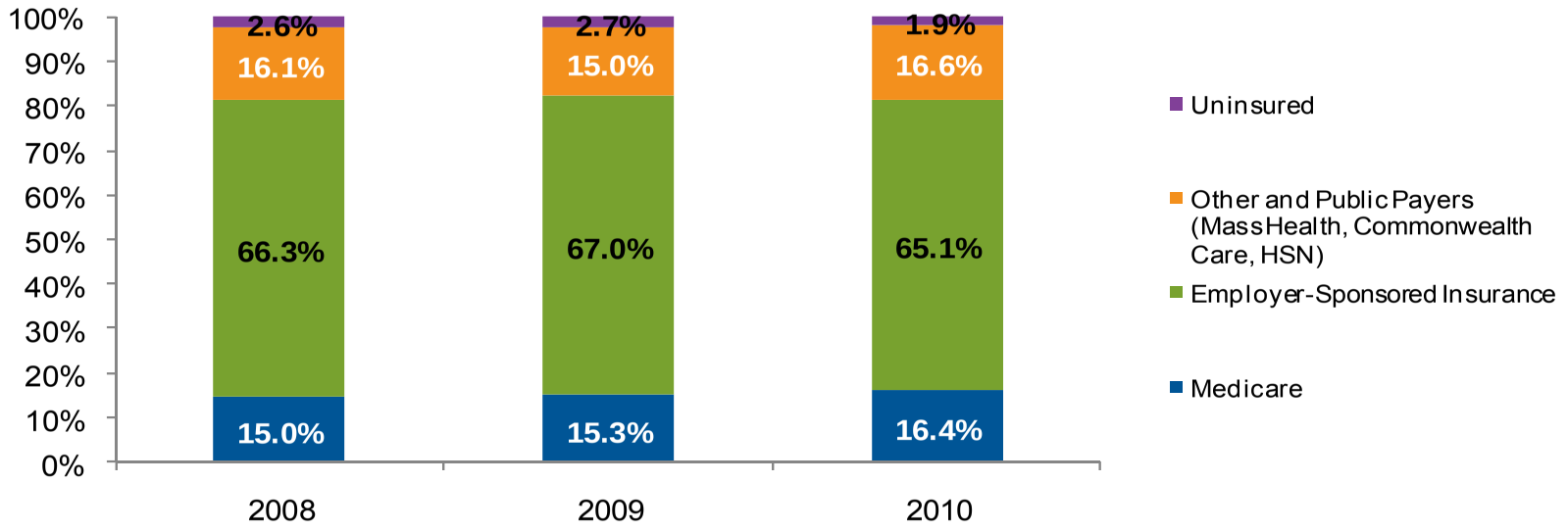
1. Methodologies should be identified for evaluating appropriate prices that reflect the delivery of care.
2. Provider prices should vary for justifiable reasons, including quality of care.
3. Justifiable factors in price variation should be transparent to all interested parties and communicated in a manner easily understood by consumers.
4. State government should take necessary steps to improve health services market functionality when market dysfunction is resulting in increasing health care spending and unjustified price variation.
5. Unjustified variation in provider prices should be reduced responsibly, and changes should be evaluated for intended and unintended consequences.
6. Any strategy to reduce the variation in provider prices must reduce the total cost of health care.

Massachusetts Health Care Landscape

Data sources:
Division of Health Care Finance and Policy (DHCFP) 2010 and 2011 Cost Trends data
Office of the Attorney General (AGO) 2010 and 2011 Cost Trends data

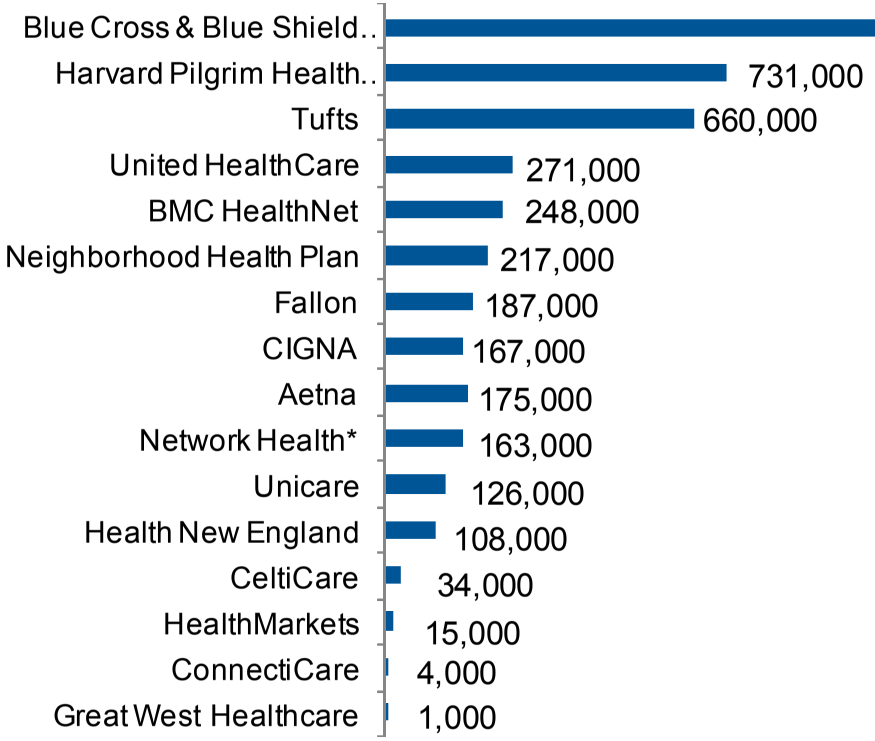
Insured Population by Insurance Type, 2006-2010

- Most Massachusetts residents (65%) are insured through their employer.
- One-third of Massachusetts residents are enrolled in public plans such as Medicare or Medicaid.
- 1.9% of Massachusetts residents were uninsured in 2010.



Source: Division of Health Care Finance and Policy, *Household Health Insurance Survey 2010*, December 2010. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf (last accessed 7/7/2011).

Enrollment by Insurer as of September 30, 2010



- Blue Cross Blue Shield of Massachusetts (BCBS) represents 41% of covered lives.
- BCBS, Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) represent over two-thirds of the market.
- This chart includes enrollment in Medicaid managed care organizations (MCOs) and Medicare Advantage.

Source: Division of Health Care Finance and Policy, *Health Care in Massachusetts: Key Indicators* (February 2011 Edition), June 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/2011_key_indicators_february.pdf (last accessed 7/7/2011).

*Membership as of June 30, 2010

Fee-for-service remains the predominant payment method for physician services in both commercial and public plans

Commercial Payers

- Carriers reported paying all physicians on a fee-for-service (FFS) basis for PPO products.
- Nearly all physicians were also paid on a FFS basis within HMO products. The average percent of primary care physicians receiving capitation payments in HMO products is 16%. For specialists, the average was 5%.
- The payment landscape has likely shifted since Blue Cross Blue Shield of Massachusetts introduced its Alternative Quality Contract, a capitation-based payment arrangement, in 2009.

Public Payers

- Capitation arrangements are more common in public plans, but FFS still dominates.
- The average percent of primary care physicians paid on a FFS basis was 81% in 2009. For specialists, this figure was 97%.

Source: Division of Health Care Finance and Policy 2010 Cost Trends Report, *Provider Payment: Trends and Methods in the Massachusetts Health Care System*, February 2010. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part1_payment_methods_final.pdf (last accessed 7/7/2011). Each carrier reported the percent of physicians they pay with each method, in the following ranges: 1□9%, 10□49%, 50□79%, 80□99%, or 100%. The average percent of physicians paid with the method is calculated as the average of the midpoints of the ranges reported by carriers that used the payment method.

Health Care Premium Trends

- Health insurance premiums reflect the underlying price, cost, and use of medical services. Changes in premiums may mirror changes in these primary inputs.

- For the 2011 Cost Trends reports, DHCFP reviewed health insurance premium data between 2007 and 2009.
  - *Unadjusted* premiums are the actual premiums paid by members, per member per month (PMPM).
  - *Adjusted* premiums control for benefit levels and demographics and allow for comparisons across years.

- In general, premiums increased from 2007 to 2009 despite a decline in the level of benefits covered by private group health insurance and greater member cost-sharing.

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Premium Levels and Trends in Private Health Plans, 2007-2009*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/premium_report.pdf (last accessed 7/7/2011).

Adjusted health insurance premiums increased 5% to 10% from 2007-2009

- From 2007 to 2009, private group health insurance premiums in Massachusetts increased roughly 5% to 10% annually, when adjusted for benefits.
- Due primarily to benefit reductions, actual premium increases were lower than adjusted increases.
- This compares to inflation (CPI-U) increases of 1.7% annually nationwide and 2.0% in the Northeast.

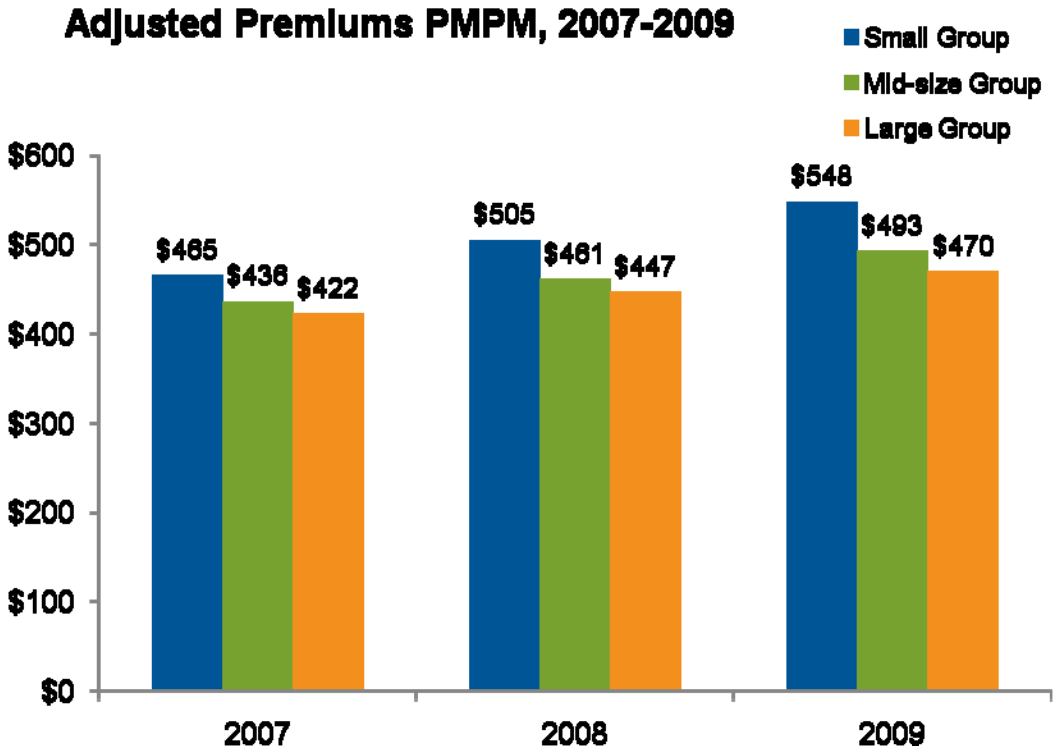
Unadjusted Premium PMPM Percent Change		
	2007-2008	2008-2009
Small Group	5.8%	2.2%
Mid-Size Group	5.2%	5.6%
Large Group	6.1%	4.3%

Adjusted Premium PMPM Percent Change		
	2007-2008	2008-2009
Small Group	9.8%	9.5%
Mid-Size Group	6.1%	7.6%
Large Group	6.2%	5.4%

Source: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Premium Levels and Trends in Private Health Plans, 2007-2009*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/premium_report.pdf (last accessed 7/7/2011).

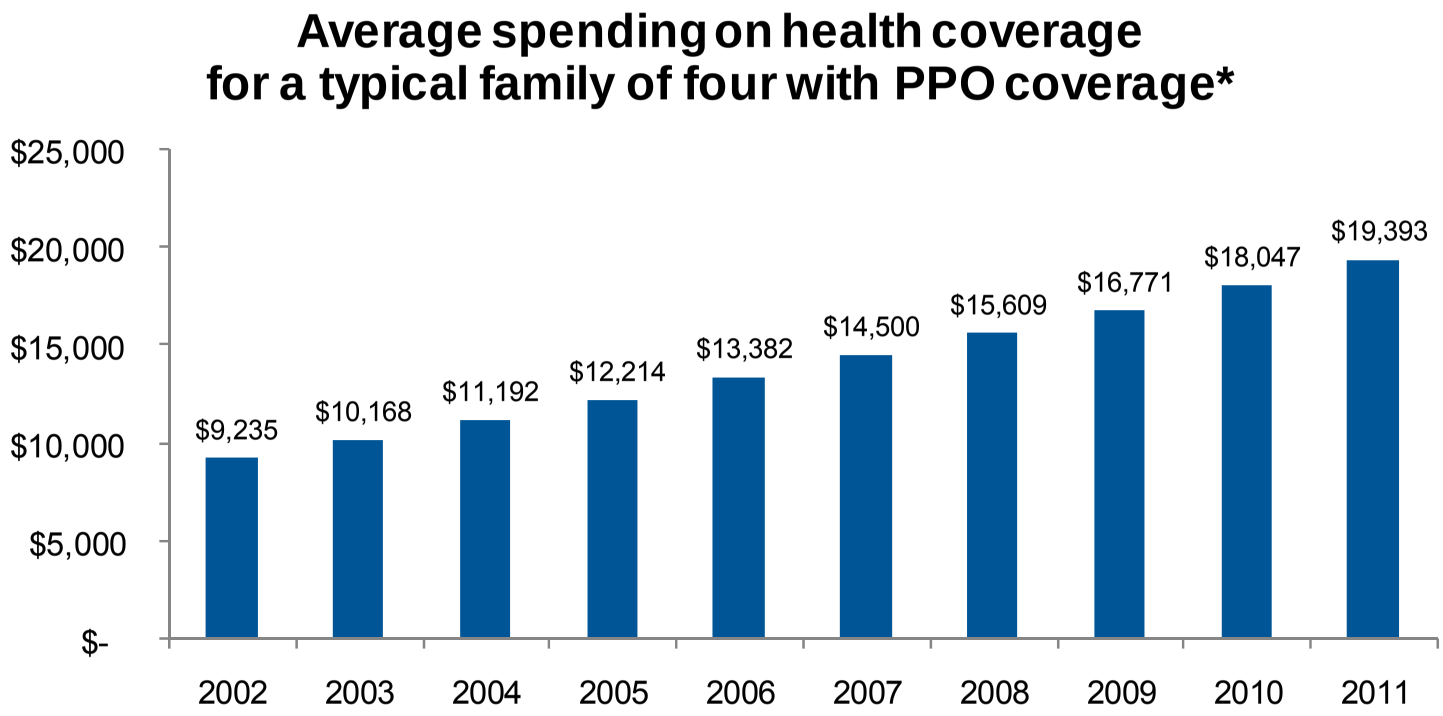
In 2009, small group premiums were higher than mid-size and large group premiums

- Smaller groups paid higher premiums from 2007 to 2009 than mid-size and large groups, when adjusted for demographics, geographic area, and benefits.
- It is important to note that premium increases for specific employers may vary significantly from the average.



Source: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Premium Levels and Trends in Private Health Plans, 2007-2009*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/premium_report.pdf (last accessed 7/7/2011).

Rising premiums and out-of-pocket payments for health coverage



*Includes employer and employee contribution to health insurance premiums as well as patient out of pocket payments.
Source: 2011 Milliman Medical Index, May 2011.

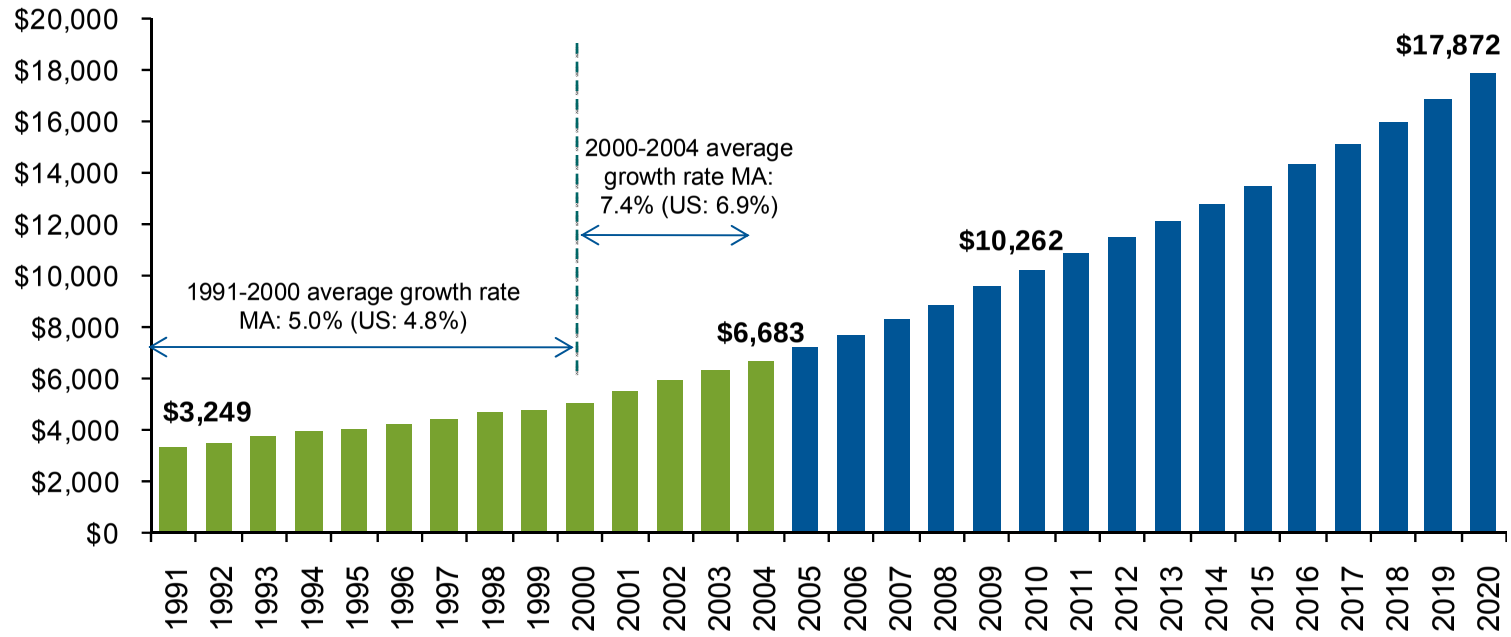
Relationship of premiums to payments

- Health insurance premiums may reflect additional factors beyond payments for health care services, including:
  - Administrative costs and margin
  - Consideration of future costs
  - Marketing goals (which may lower premiums)
  - Influence of state government

- The Massachusetts average medical loss ratio (MLR) was approximately 91% in 2009, an increase from 2007 (88%), and higher than is seen nationally.
  - Preliminary data for 2010 indicate that medical loss ratios decreased to 89% in light of slowed increase in medical claims expenditures.

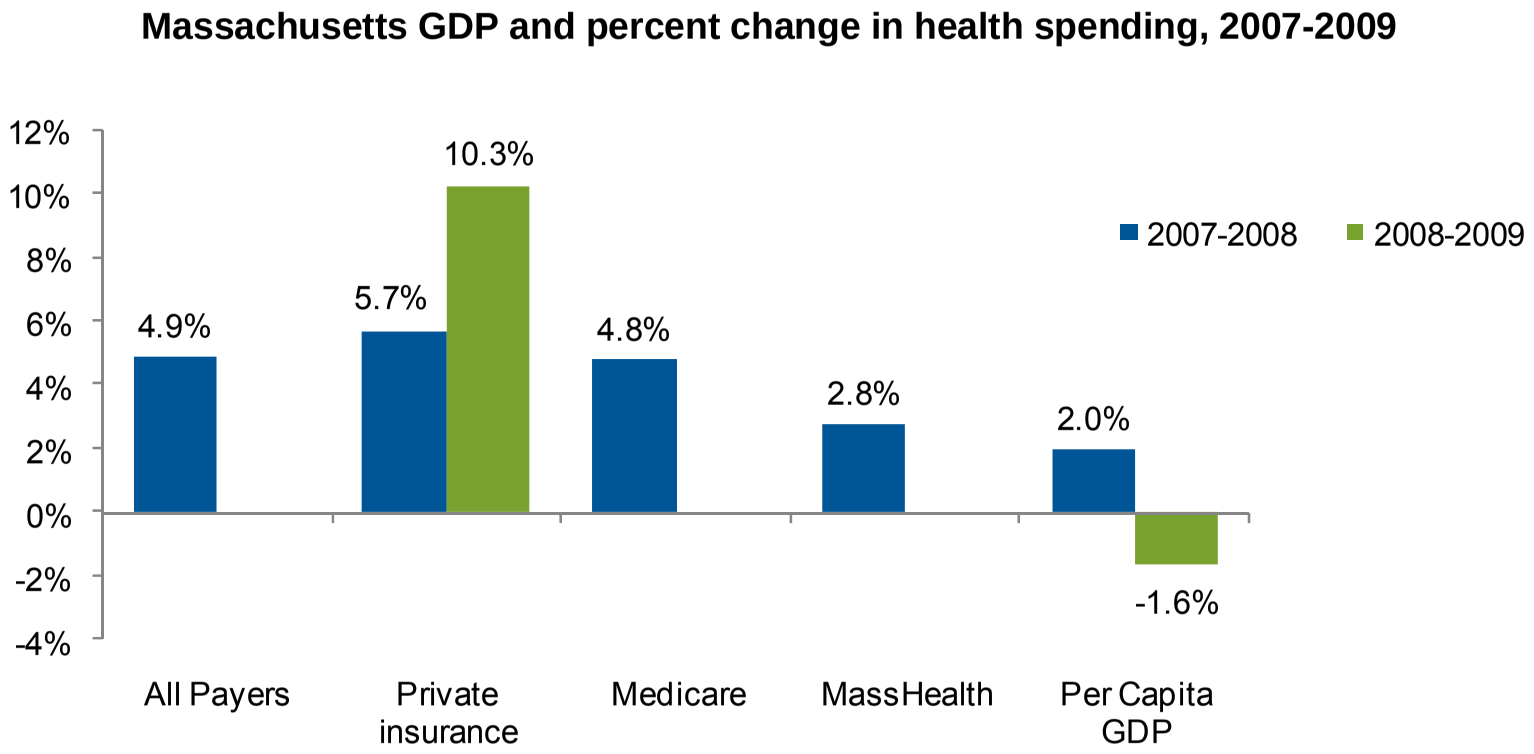
Massachusetts health care expenditures are projected to increase by over 70% between now and 2020

Massachusetts Per Capita Health Care Expenditures: 1991-2004
Massachusetts Projected Per Capita Health Care Expenditures: 2005-2020



Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. Projections by the Division of Health Care Finance and Policy.
Note: Data for 2005 – 2020 are projected assuming 7.4% growth through 2010 and then 5.7% growth through 2020.

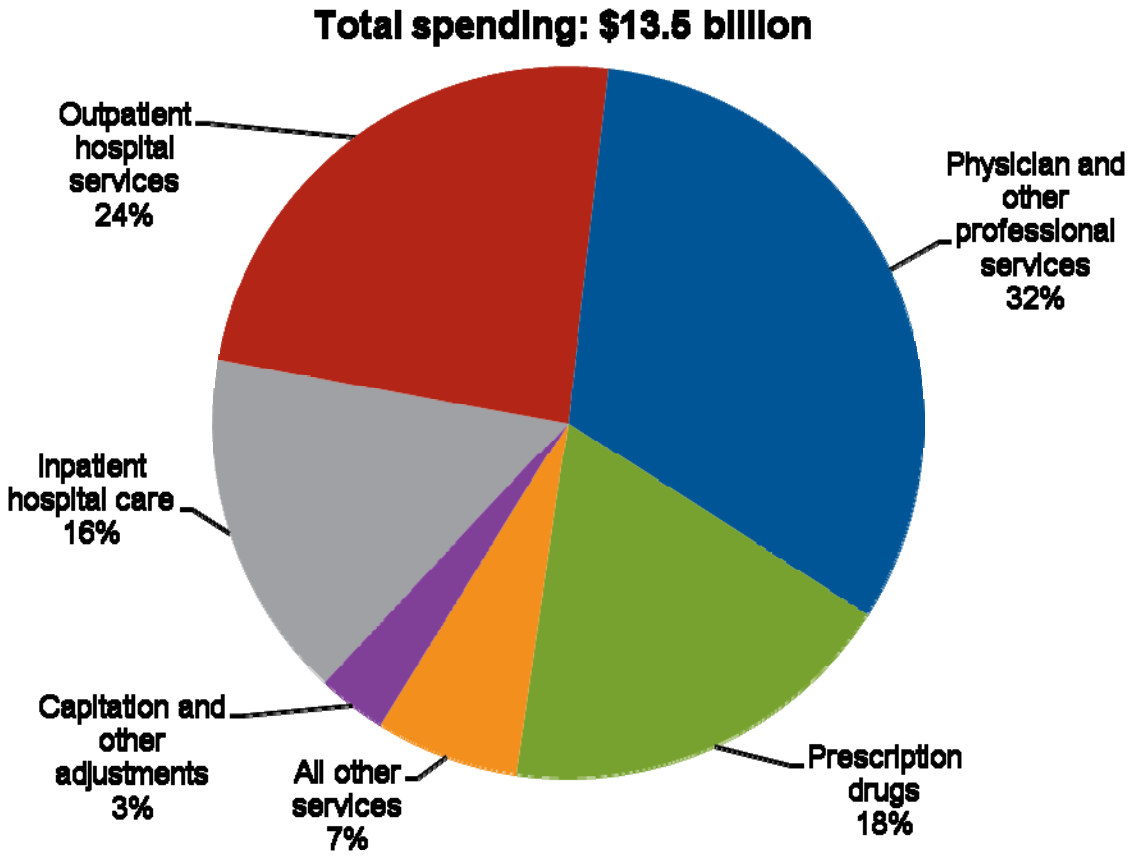
Increases in private insurance spending outpace public spending and per capita GDP growth



Source: Mathematica Policy Research analysis of private, Medicare, and MassHealth claims for Massachusetts residents. U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product by State, available at http://www.bea.gov/regional/index.htm (last accessed 7/7/2011).
Note: Health care spending estimates include patient cost-sharing.

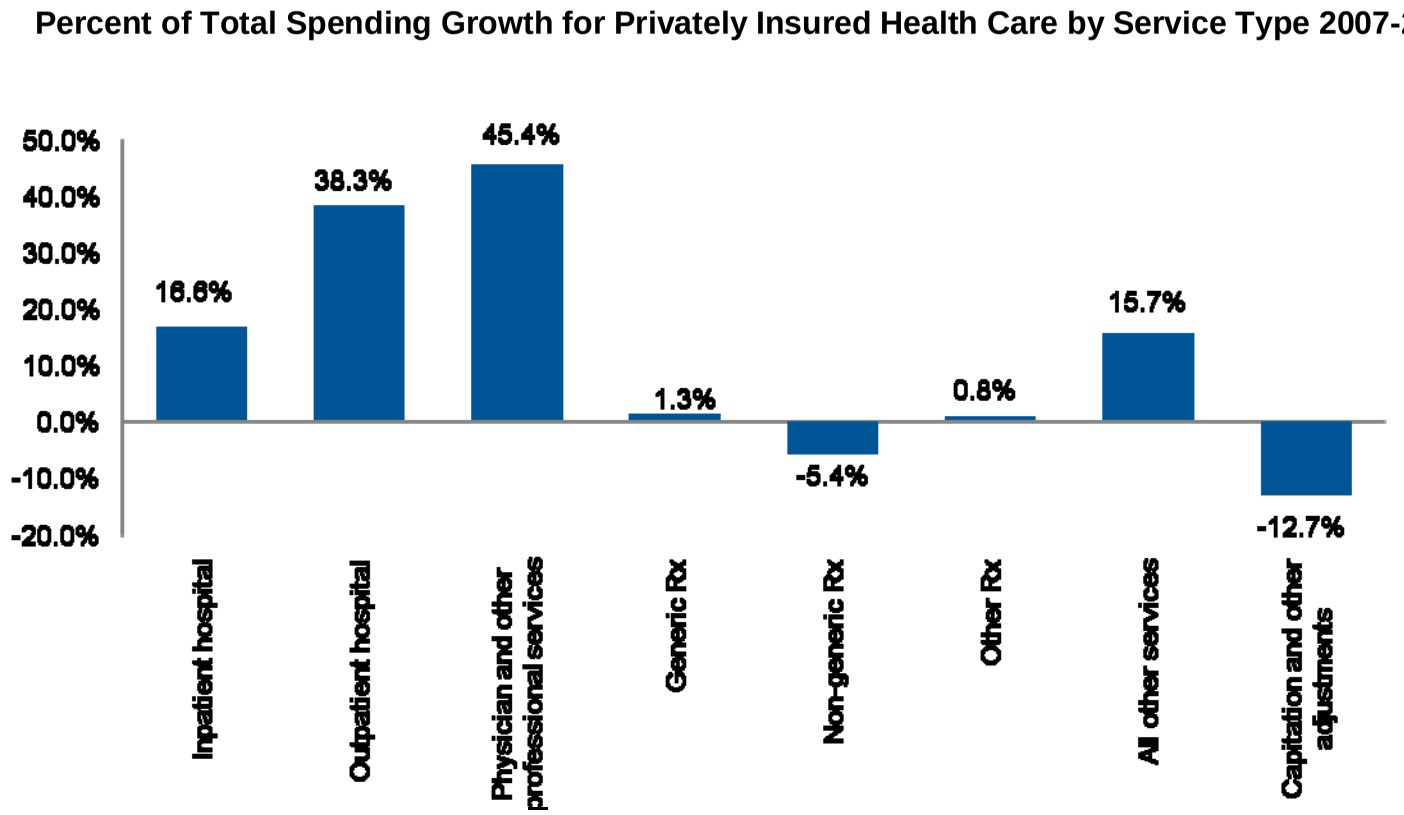
Distribution of Total Private Insured Spending in Massachusetts by Type of Service, 2009

Spending on hospital and physician services represented 72% of total 2009 private health care spending



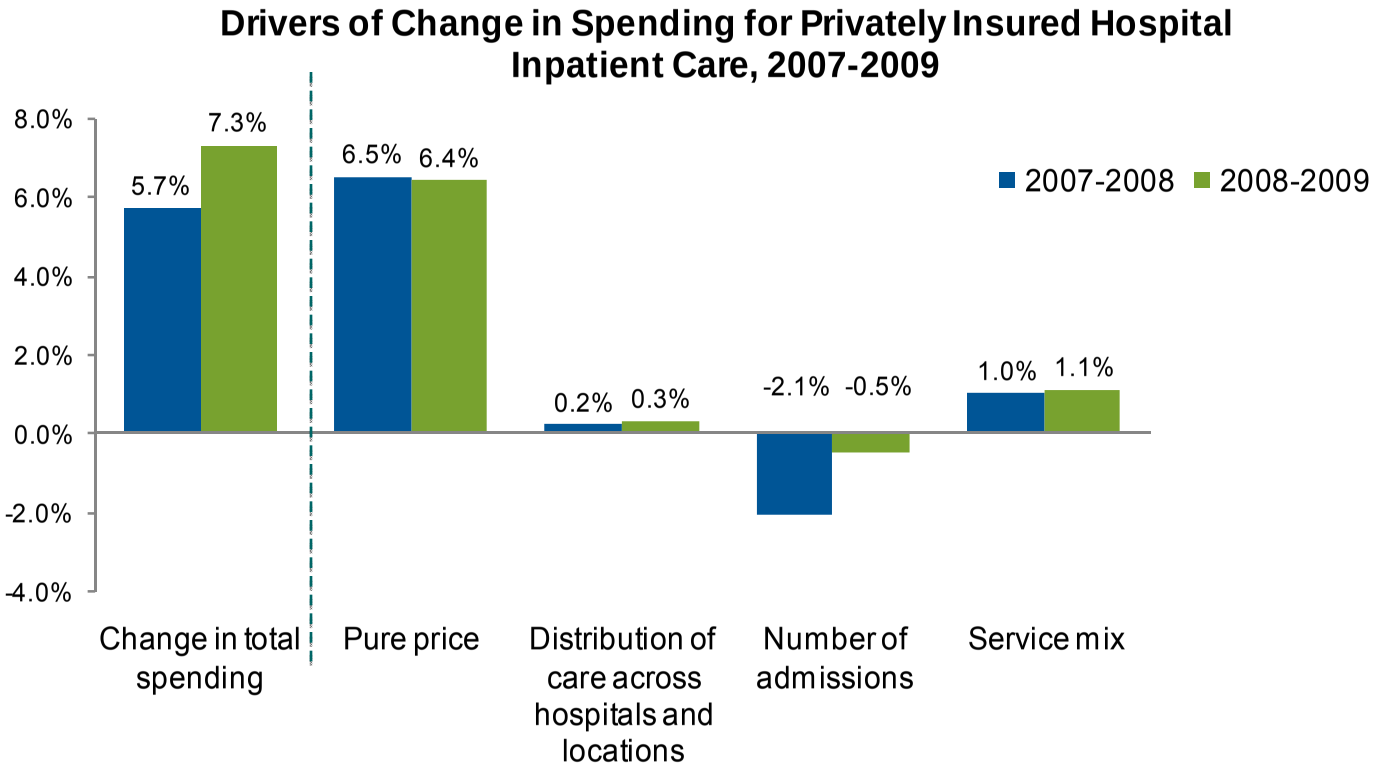
Source: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 7/7/2011). Mathematica Policy Research analysis of private claims data for Massachusetts residents in insured and self-insured plans. Contains data from the five largest carriers in Massachusetts, representing the costs of approximately 43% of all statewide residents.

The two largest areas of spending, outpatient hospital and physician services, are also growing the fastest



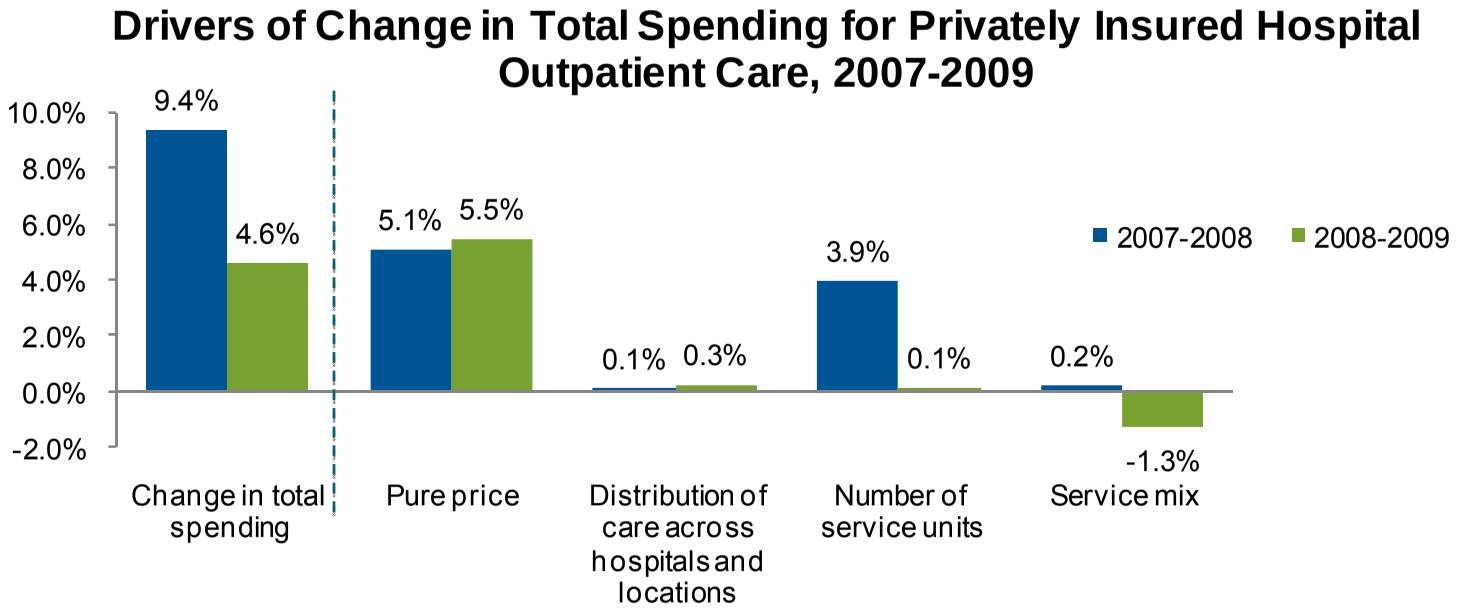
Source: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 7/7/2011).
Mathematica Policy Research analysis of private claims data for Massachusetts residents in insured and self-insured plans.
Notes: Inpatient and outpatient facility expenditures exclude professional services billed separately. All other claims include skilled nursing facilities, non-acute institutional care, and other unclassified claims. Other adjustments include reconciliation of total capitation payments and the fee-for-service equivalents that carriers reported at the claims level, plus other reported payments such as pay-for-performance incentive payments and network management fees that did not flow through the claims system.

Faster growth in hospital inpatient spending by private payers was largely the result of increasing prices



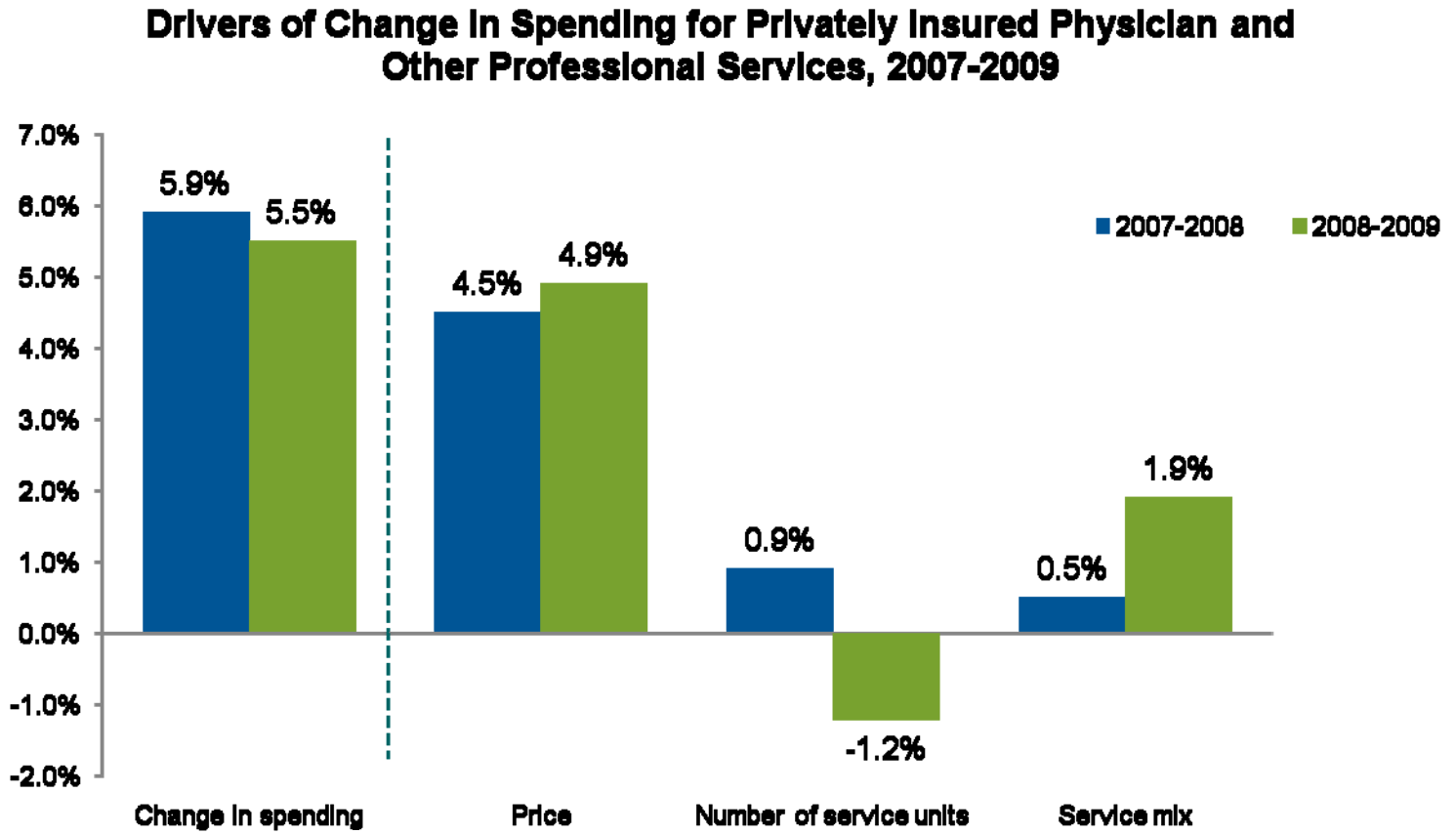
SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 7/7/2011).
Mathematica Policy Research analysis of private insurance, Medicare, and MassHealth claims for Massachusetts residents.

Increases in prices accounted for virtually all of the privately insured hospital outpatient cost growth from 2008 to 2009



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 7/7/2011).
Mathematica Policy Research analysis of private insurance, Medicare, and MassHealth claims for Massachusetts residents.

For physician and other professional services, higher prices explained a significant amount of the cost growth between 2007 and 2009



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 7/7/2011).
Mathematica Policy Research analysis of private insurance, Medicare, and MassHealth claims for Massachusetts residents.

Potential causes of health care price increases identified in literature

- Investments in new and emerging technology
- Labor costs
  - Economists theorize that service industry wages must increase even if productivity doesn't, especially in labor-intensive industries. As a result, unit costs for service industries like health care rise more rapidly than the economy.
- Increasing demand
  - Population demographics and changes in health status.
- Third-party payment
  - Consumers are insulated from the economic consequences of their health care choices and may not have price or performance information to influence their decisions.
- Decreased market competition
- Service mix and provider mix

Provider Price Variation Analyses

Section 67 of Chapter 288 of the Acts of 2010

The commission shall examine:

- **the variation in relative prices paid to providers within similar provider groups;**
- the variation in costs of providers for services of comparable acuity, quality, and complexity;
- the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses;
- the correlation between price paid to providers and
  - the quality of care,
  - the acuity of the patient population,
  - the provider's payer mix,
  - the provision of unique services, including specialty teaching services and community services, and
  - operational costs, including labor costs;
- the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and
- policies to promote the use of providers with low health status adjusted total medical expenses.

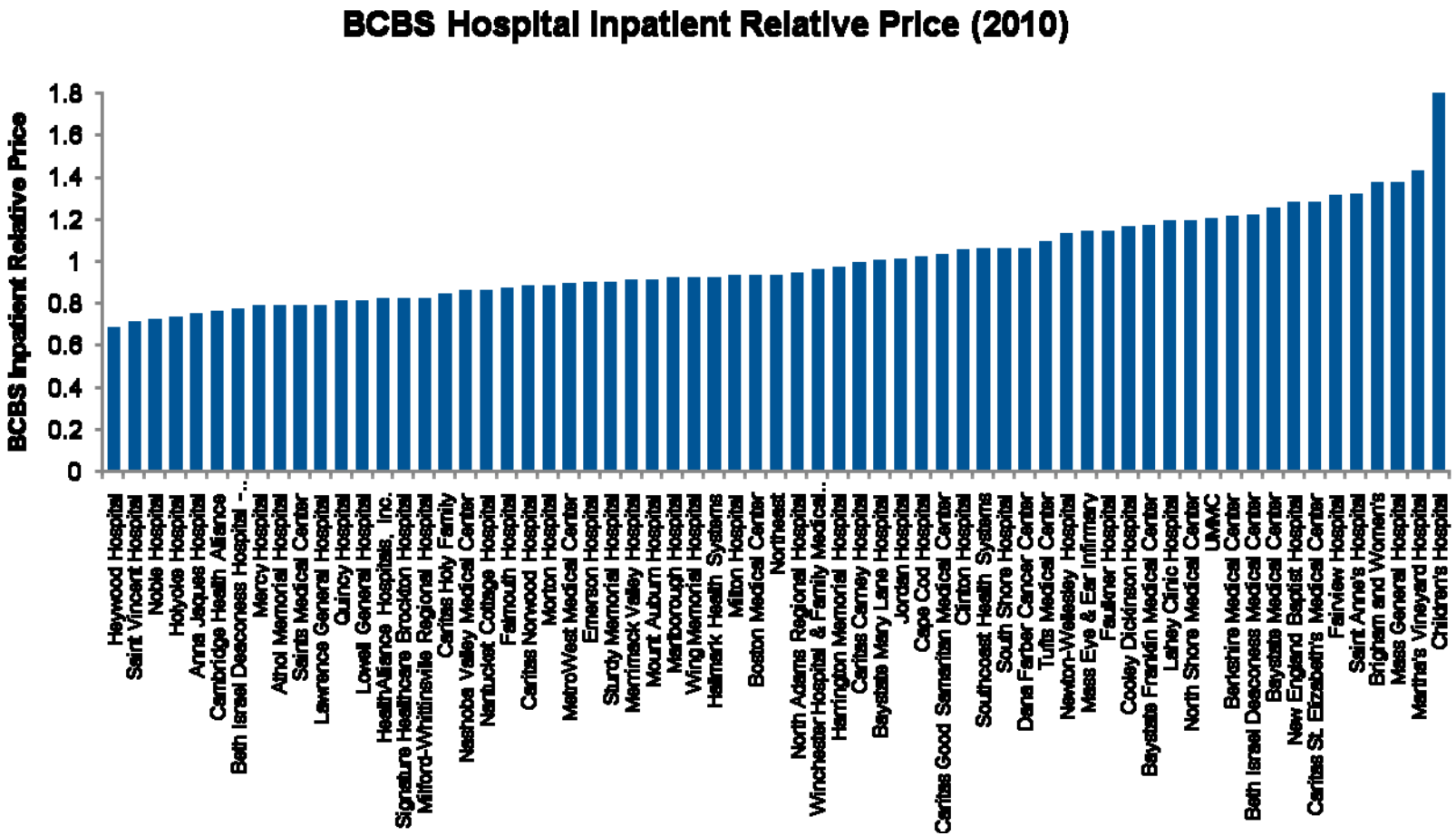
Variation in relative prices paid to providers

- For the 2010 and 2011 Cost Trends hearings, the AGO collected relative price or relative payment data from the three largest commercial insurers.
  - Relative prices do not reflect volume, product mix, service mix, or other factors particular to a provider's payment history. They illustrate "pure price level" differences. This type of data was submitted by BCBS and THP.
  - Relative payments reflect the hospital-specific volume and service mix, typically adjusted for acuity. Relative payments illustrate differences in payments for the services each hospital provides and therefore do not represent "pure price." Relative payment data was provided by HPHC.

- **Findings:**
- There is wide variation in the prices paid by health insurers to providers.

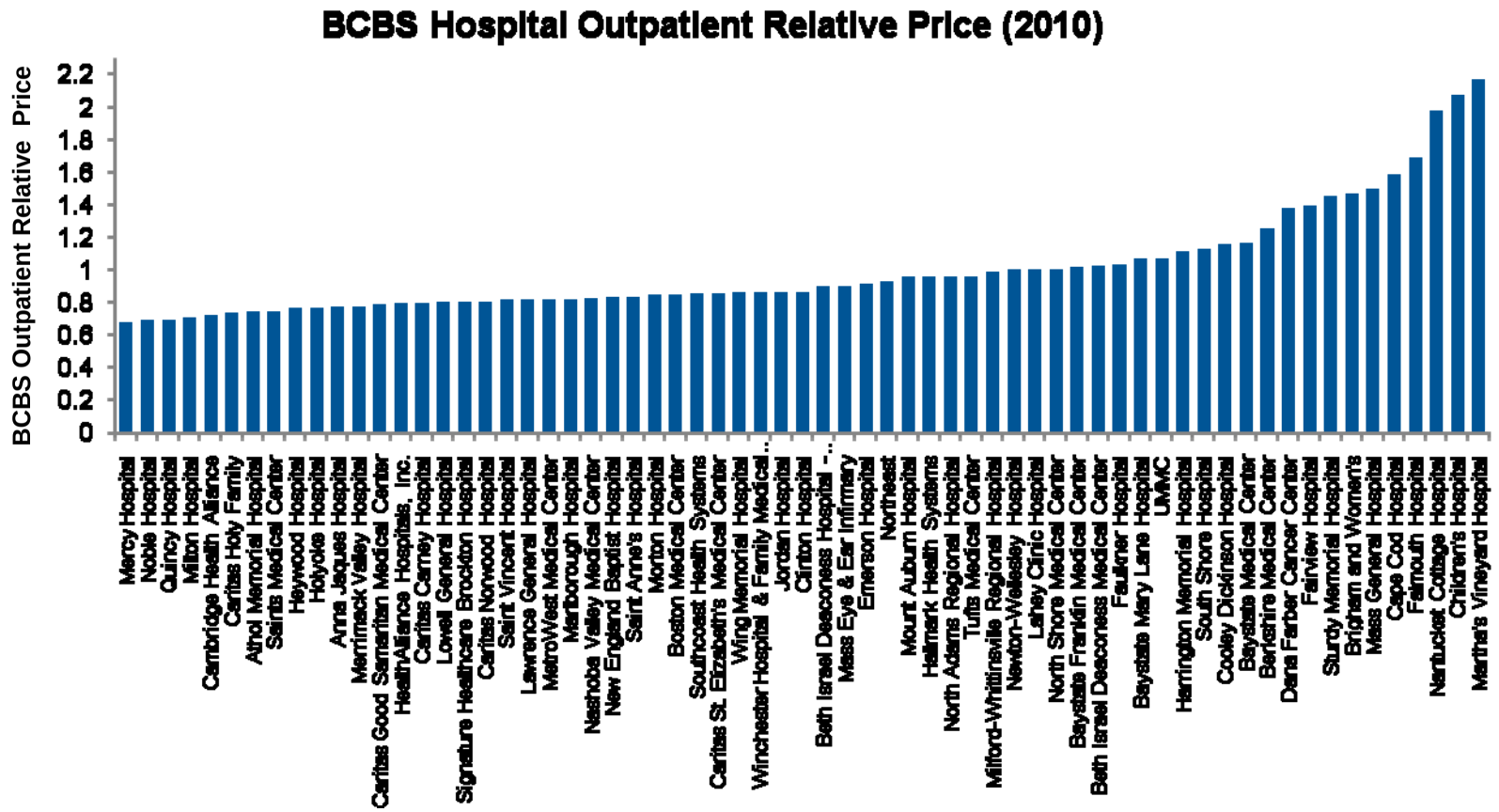
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative inpatient prices among hospitals in the BCBS network varied by 165% in 2010



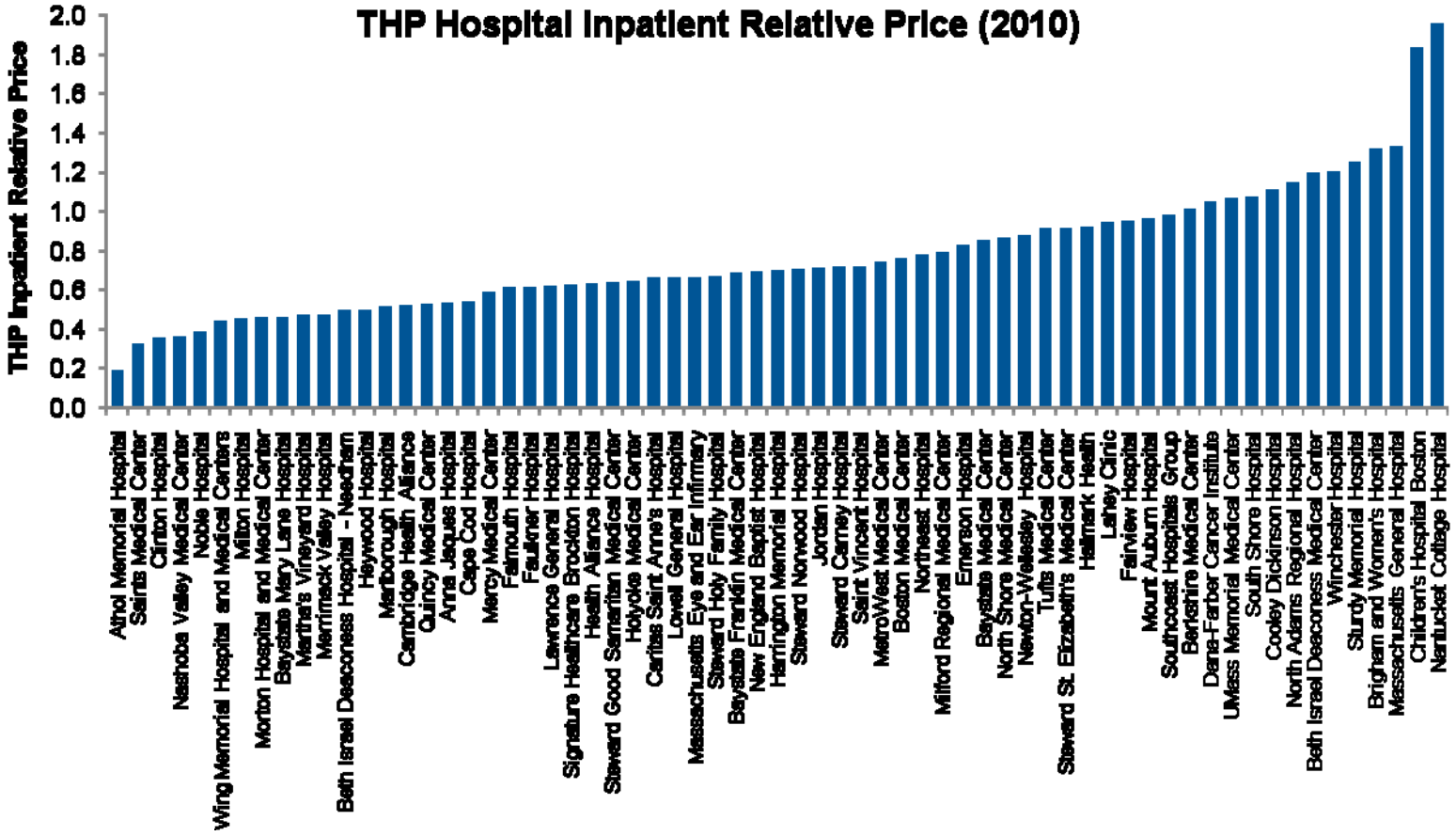
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative outpatient prices among hospitals in the BCBS network varied by 222% in 2010



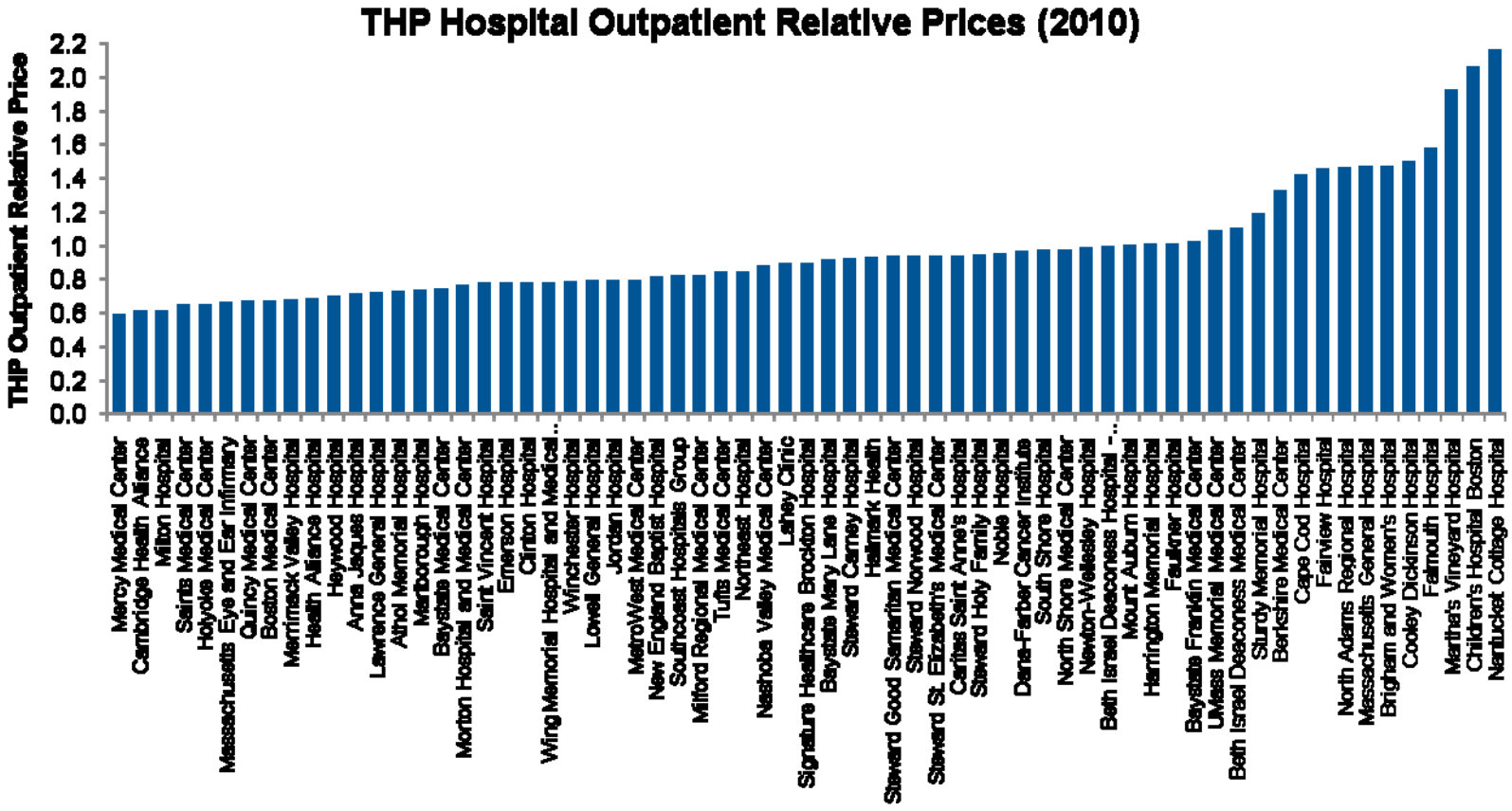
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative inpatient prices among hospitals in the THP network varied by 955% in 2010



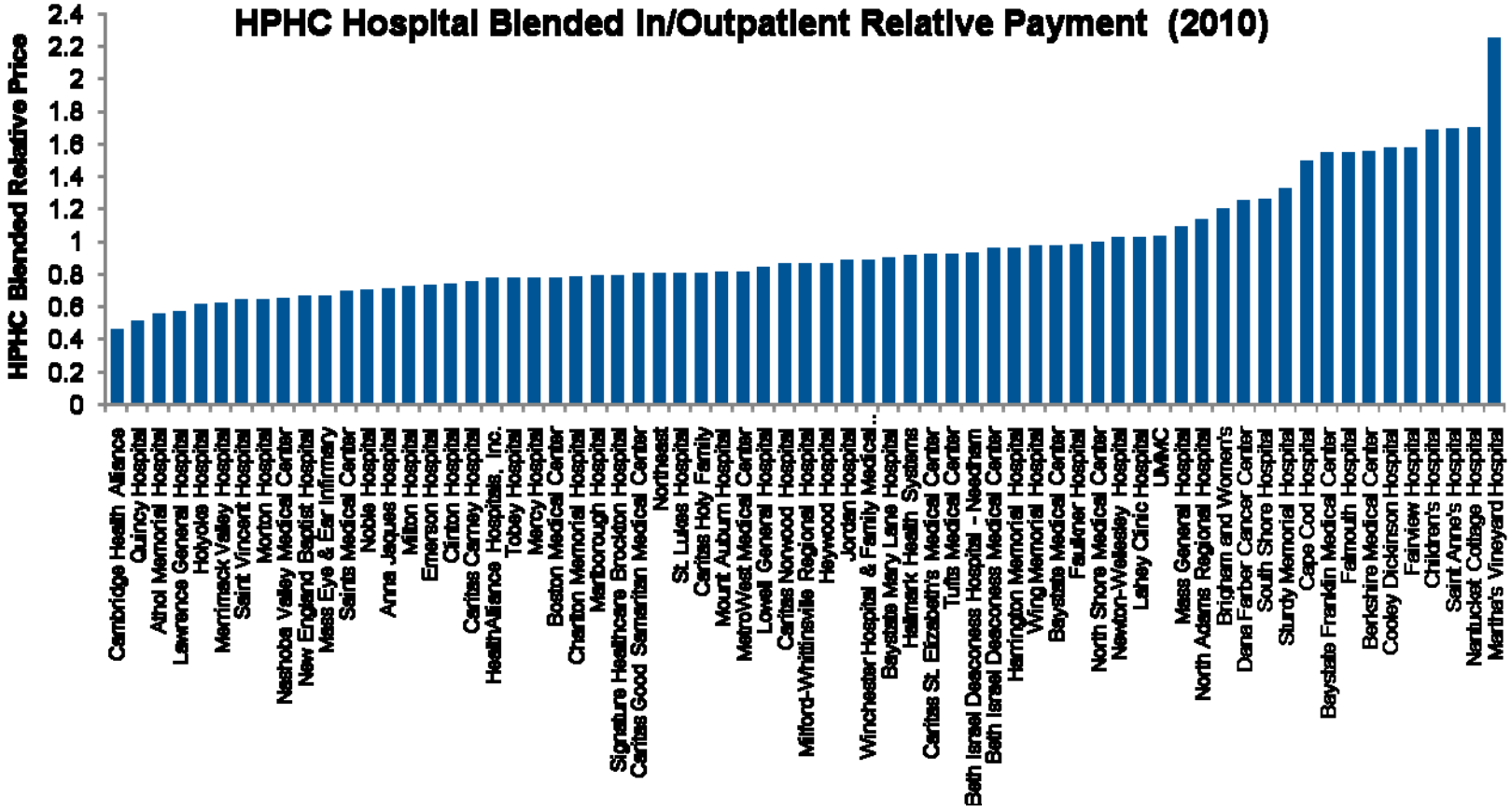
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative outpatient prices among hospitals in the THP network varied by 268% in 2010



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative payments among hospitals in the HPHC network varied by 389% in 2010



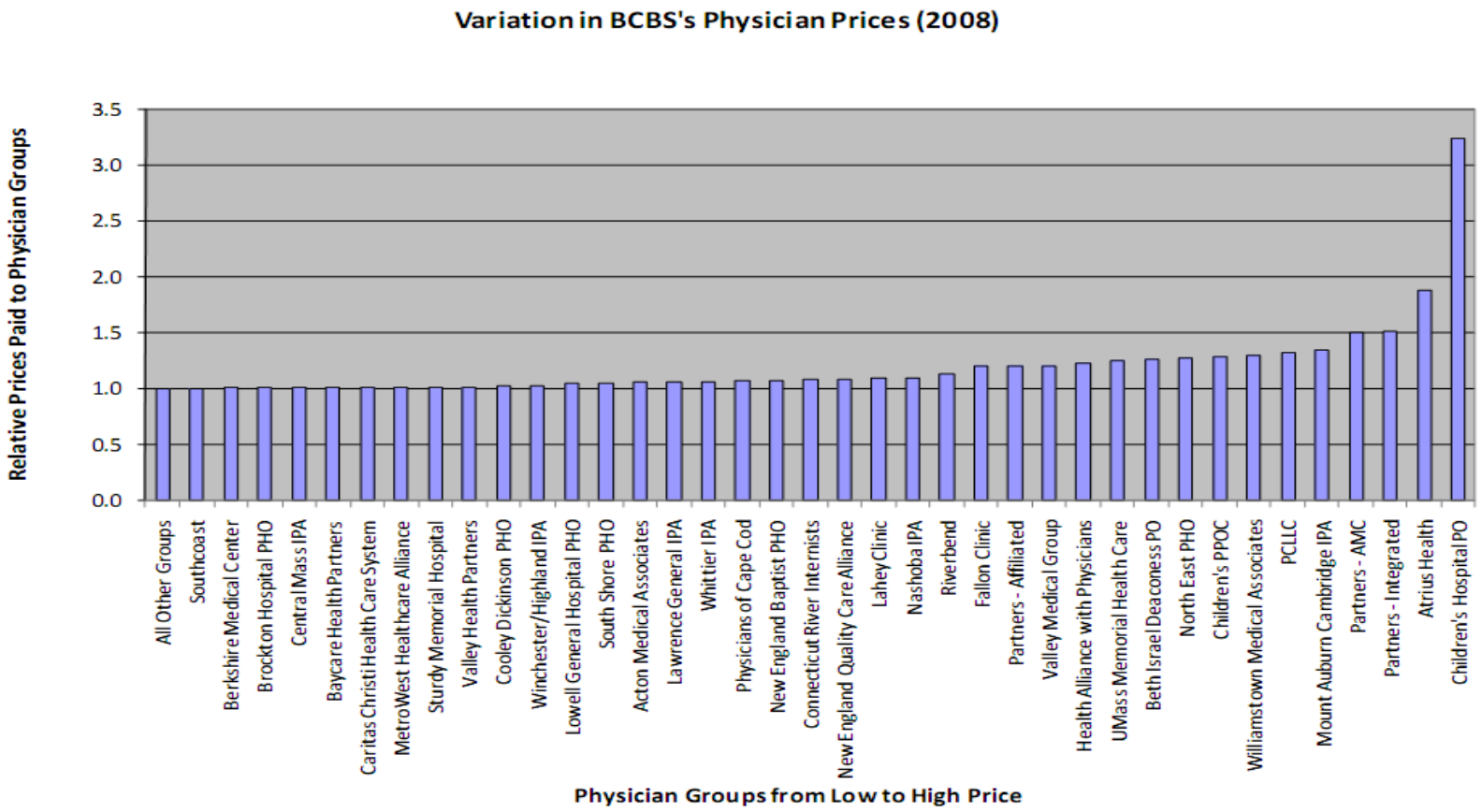
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).
NOTE: HPHC reported a blended hospital relative payment rather than a separate inpatient and outpatient relative payment.

Summary of Hospital Price / Payment Variation

Payer	Year	Variation within Network
BCBS (Inpatient)	2010	165%
BCBS (Outpatient)	2010	222%
THP (Inpatient)	2010	955%
THP (Outpatient)	2010	268%
HPHC (Blended)	2010	389%

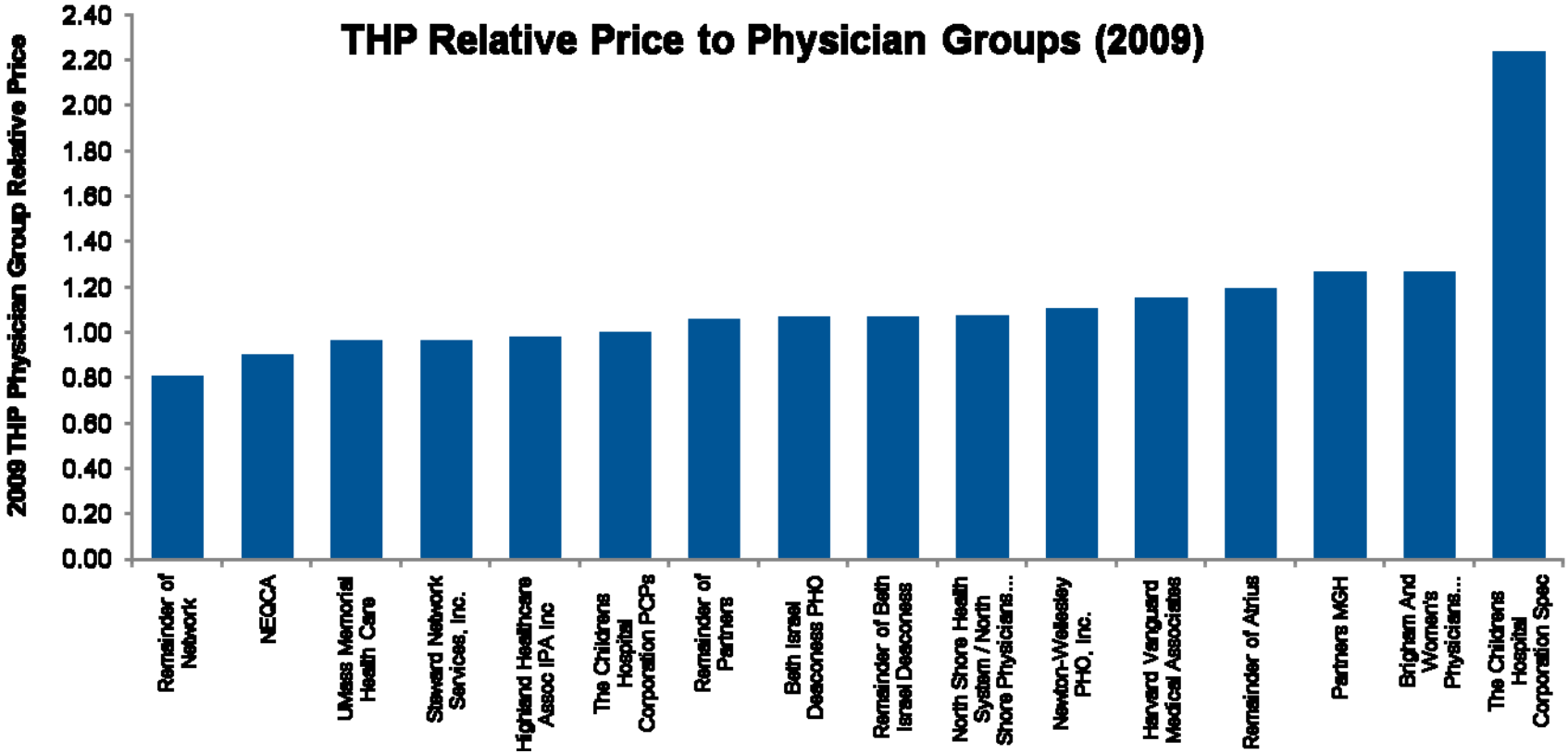
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative prices among physician groups in the BCBS network varied by 225% in 2008



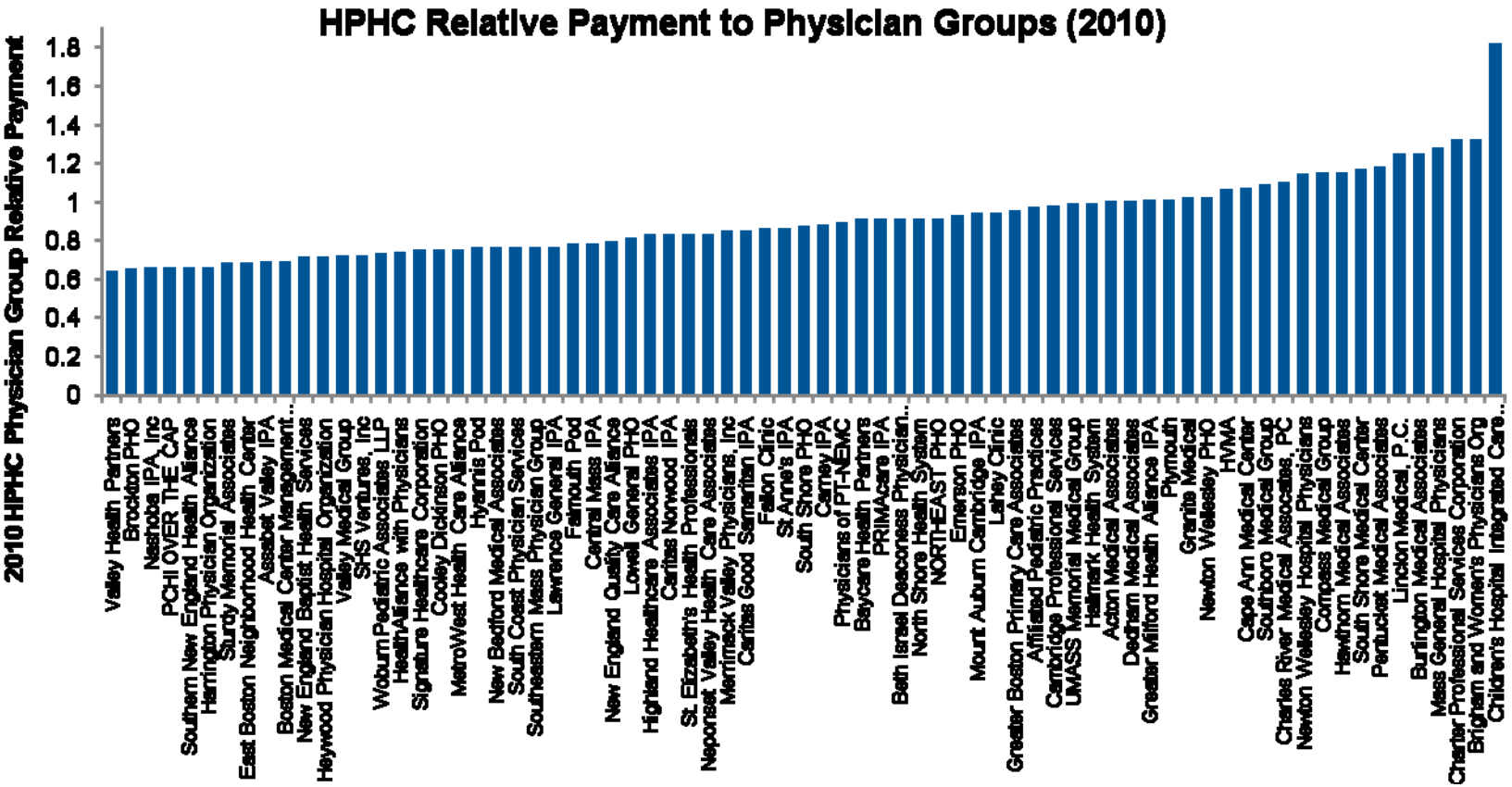
SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative prices among physician groups in the THP network varied by 177% in 2009



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Relative payments among physician groups in the HPHC network varied by 184% in 2010



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Summary of Physician Group Price/Payment Variation

Payer	Year	Variation within Network
BCBS	2008	225%
THP	2009	177%
HPHC	2010	184%

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).

Section 67 of Chapter 288 of the Acts of 2010

The commission shall examine:

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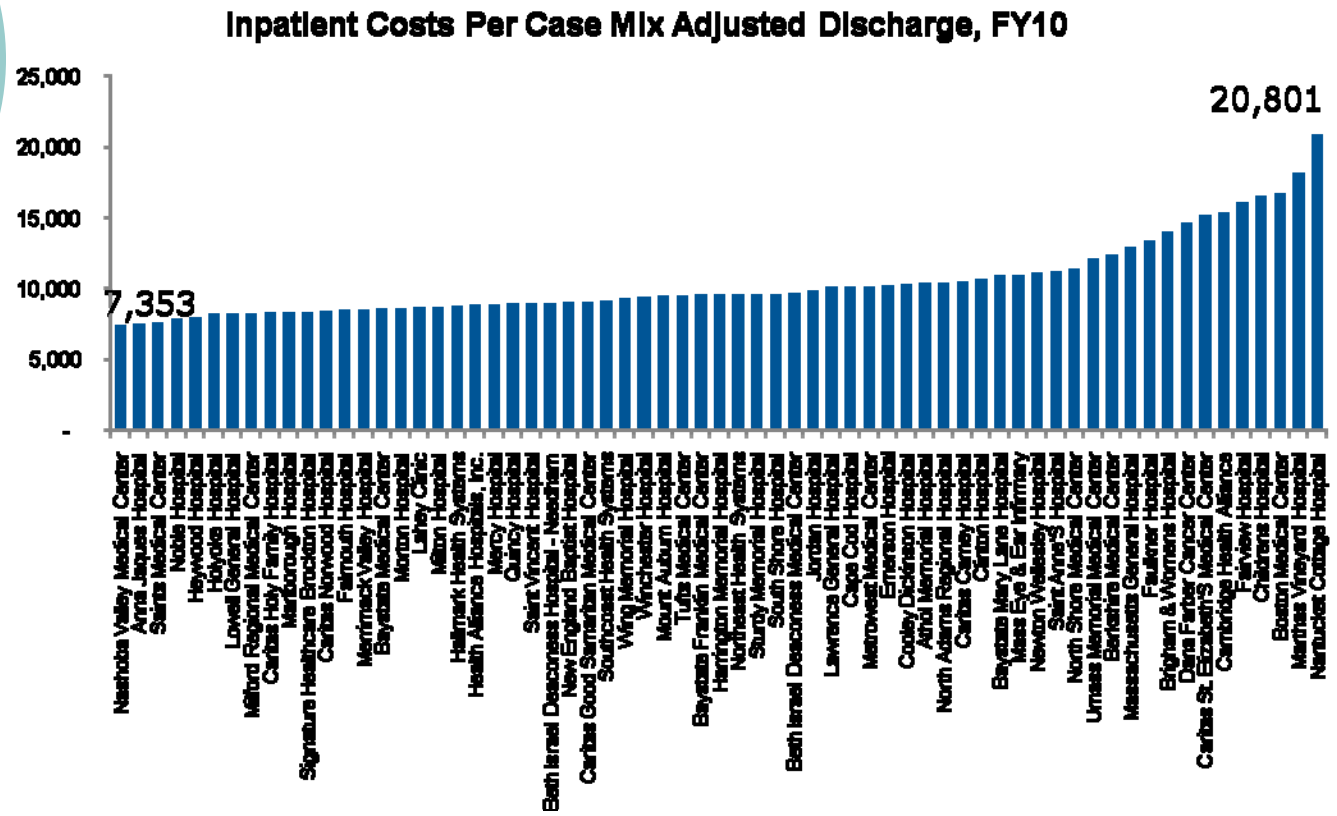
  - operational costs, including labor costs;
- the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and
- policies to promote the use of providers with low health status adjusted total medical expenses.

Inpatient costs per discharge, adjusted for patient acuity, varied by 183% in FY10



Hospital inpatient cost per case mix adjusted discharge ranged from a low of $7,353 at Nashoba Valley Medical center to $20,801 at Nantucket Cottage Hospital.

Inpatient costs include patient care and teaching expenses, and exclude research and other non-patient expenses.

Source: Inpatient cost and discharge data from the 2010 DHCFP-403 hospital cost reports.
Case mix data from the FY2010 hospital discharge data set, 3M© All-payer Refined version 26 grouper.

Costs per case mix adjusted discharge are calculated as total inpatient costs divided by the product of the hospital's case mix and total discharges

Inpatient costs per discharge, adjusted for patient acuity, varied across hospital cohorts

	Median	Minimum	Maximum	Variation
Statewide	**$9,544**	**$7,353**	**$20,801**	**183%**
Teaching	$12,108	$8,532	$16,694	96%
Non-teaching	$9,324	$7,353	$20,801	183%
DSH	$9,186	$7,597	$16,694	120%
Non-DSH	$9,549	$7,353	$20,801	183%

Source: Inpatient cost and discharge data from the 2010 DHCFP-403 hospital cost reports.
Case mix data from the FY2010 hospital discharge data set, 3M© All-payer Refined version 26 grouper.

Costs per case mix adjusted discharge are calculated as total inpatient costs divided by the product of the hospital's case mix and total discharges

Variation in costs of providers for services of comparable acuity, quality, and complexity

- For the 2011 Cost Trends hearings, DHCFP examined hospital inpatient and professional prices paid by private health plans for commercially insured members.
- In each category, a sample of high volume health care services was selected.
  - For inpatient services, 14 routine diagnosis-related groups (DRGs), representing approximately 40% of private payments for all inpatient services, were included in the analysis.
  - For professional services, 20 procedure codes representing approximately 28% of all private fee-for-service payments were analyzed.

- **Findings:**
- Severity-adjusted prices paid for the same hospital inpatient services and for professional services vary significantly for every service examined.
- There is little measurable variation among Massachusetts hospitals based on the available quality metrics related specifically to the 14 selected inpatient services.

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Hospital prices vary widely within severity-adjusted DRGs

- Among the 14 DRGs examined, the largest difference between the maximum and minimum price was for Cesarean delivery at $5,560, or 113%.
- The smallest range was for congestive heart failure at $2,913, or 32%.

Diagnostic-Related Group	Private Payer Risk-Adjusted Median Price		Price Relativity		% Variation Between Min and Max Value
	Minimum	Maximum	Minimum	Maximum	
Pneumonia	$5,524	$9,225	0.75	1.26	68%
Chronic obstructive pulmonary disease	$6,160	$10,222	0.78	1.30	67%
Acute myocardial infarction	$9,684	$19,059	0.67	1.32	97%
Congestive heart failure	$9,129	$12,042	0.79	1.04	32%
Appendectomy	$6,141	$11,889	0.75	1.46	95%
Laparoscopic cholecystectomy	$7,274	$12,670	0.75	1.30	73%
Hip joint replacement	$20,010	$27,342	0.87	1.18	36%
Knee joint replacement	$14,153	$25,284	0.71	1.28	80%
Intervertebral disc excision and decompression	$6,754	$11,263	0.70	1.17	67%
Knee and lower leg procedures	$9,765	$15,732	0.73	1.18	62%
Procedures for obesity	$10,328	$18,266	0.74	1.32	78%
Uterine and adnexa procedures for non-malignancy except leiomyoma	$6,103	$10,306	0.72	1.21	68%
Cesarean delivery	$4,957	$10,517	0.70	1.49	113%
Vaginal delivery	$3,430	$6,185	0.76	1.37	80%

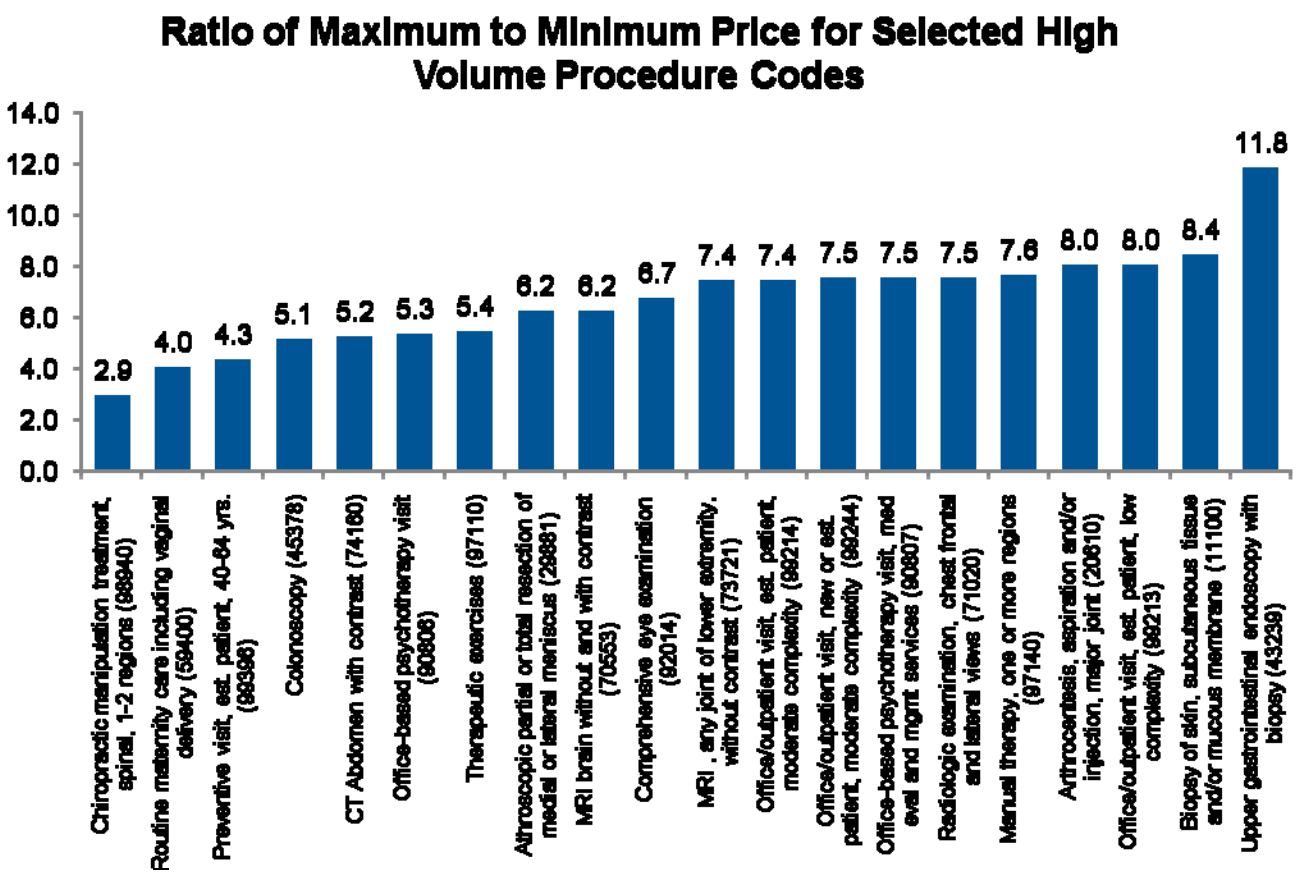
SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services,* May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

There is very little measureable variation in quality among Massachusetts hospitals for the 14 selected DRGs

DRG	Composite Quality Relativity		Range of Quality Variation
	Minimum	Maximum	
Pneumonia	.97	1.03	6.2%
Chronic obstructive pulmonary disease	.92	1.13	22.8%
Acute myocardial infarction	.98	1.04	6.1%
Congestive heart failure	.96	1.04	8.3%
Appendectomy	.96	1.04	8.3%
Laparoscopic cholecystectomy	.96	1.04	8.3%
Hip joint replacement	.96	1.04	8.3%
Knee joint replacement	.96	1.04	8.3%
Intervertebral disc excision and decompression	.96	1.04	8.3%
Knee and lower leg procedures	.96	1.04	8.3%
Procedures for obesity	.96	1.04	8.3%
Uterine and adnexa procedures for non-malignancy except leiomyoma	.96	1.04	8.3%
Cesarean delivery	.97	1.02	5.2%
Vaginal delivery	.94	1.06	12.8%

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services,* May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).
Note: The quality relativity is each hospital's composite quality score for the given DRG as it relates to the statewide average composite quality score.

The ratio of the highest and lowest prices for the same procedures varied widely



Payments for the same procedures varied widely. The median ratio of highest-to-lowest prices was 7.1.

For upper gastrointestinal endoscopy with biopsy, the maximum payments were 11.8 times as high as the minimum payments.

The variation was lowest for chiropractic manipulation at 2.9.

Source: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).
Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Section 67 of Chapter 288 of the Acts of 2010

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Variation in volume of care provided at providers with low and high levels of relative prices

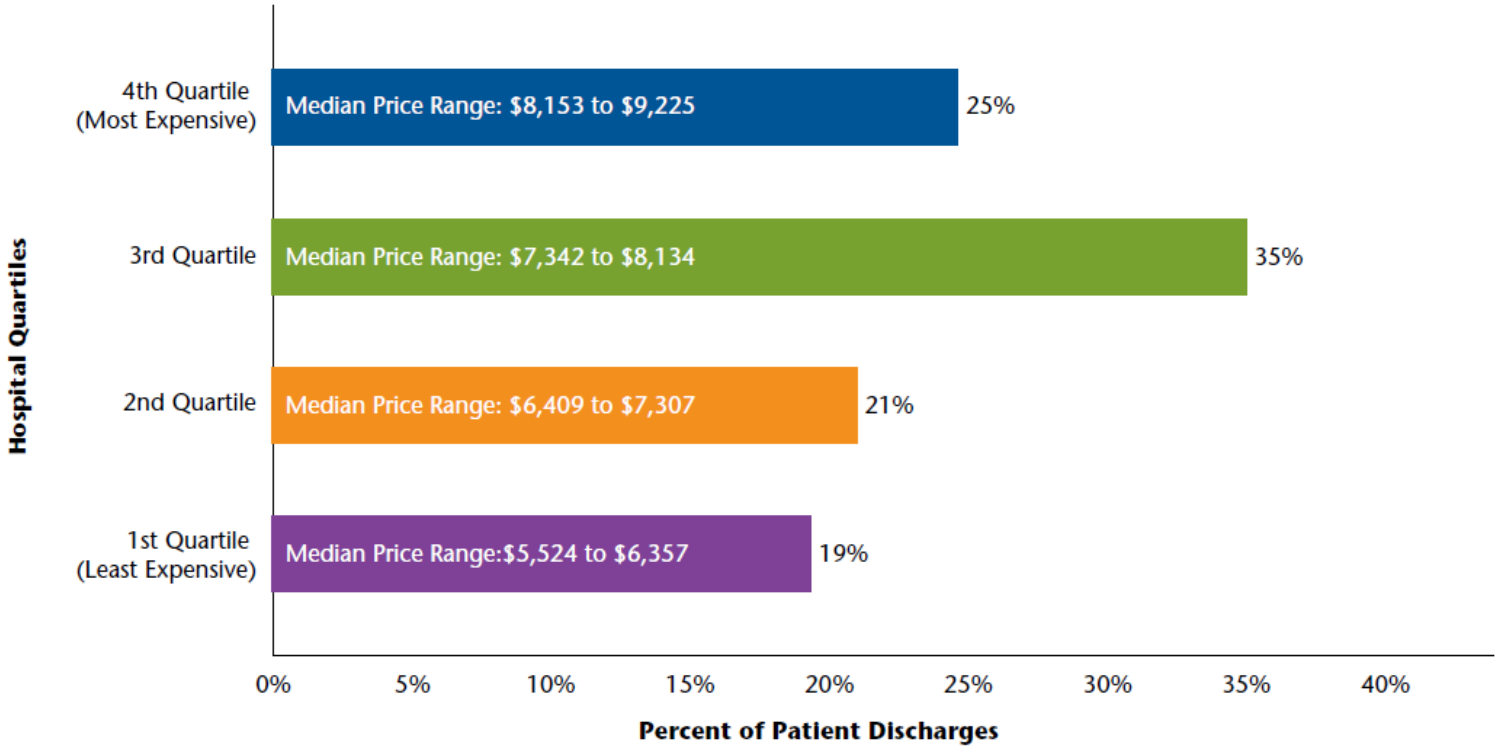
- For the 2011 Cost Trends hearings, DHCFP reviewed how hospital volume is distributed among high and low price providers.
- DHCFP used the median price for each DRG to sort hospitals into price quartiles at the DRG level, and then compared the number of discharges associated with each of these price quartiles.

Findings:

- Most volume occurs at higher price hospitals, with nearly half of vaginal deliveries and knee replacements occurring at hospitals in the highest price quartile (47% and 49%, respectively).
- Between 60% and 70% of patient volume occurred at the two most expensive quartile hospitals for each of the 14 DRGs included in the analysis.

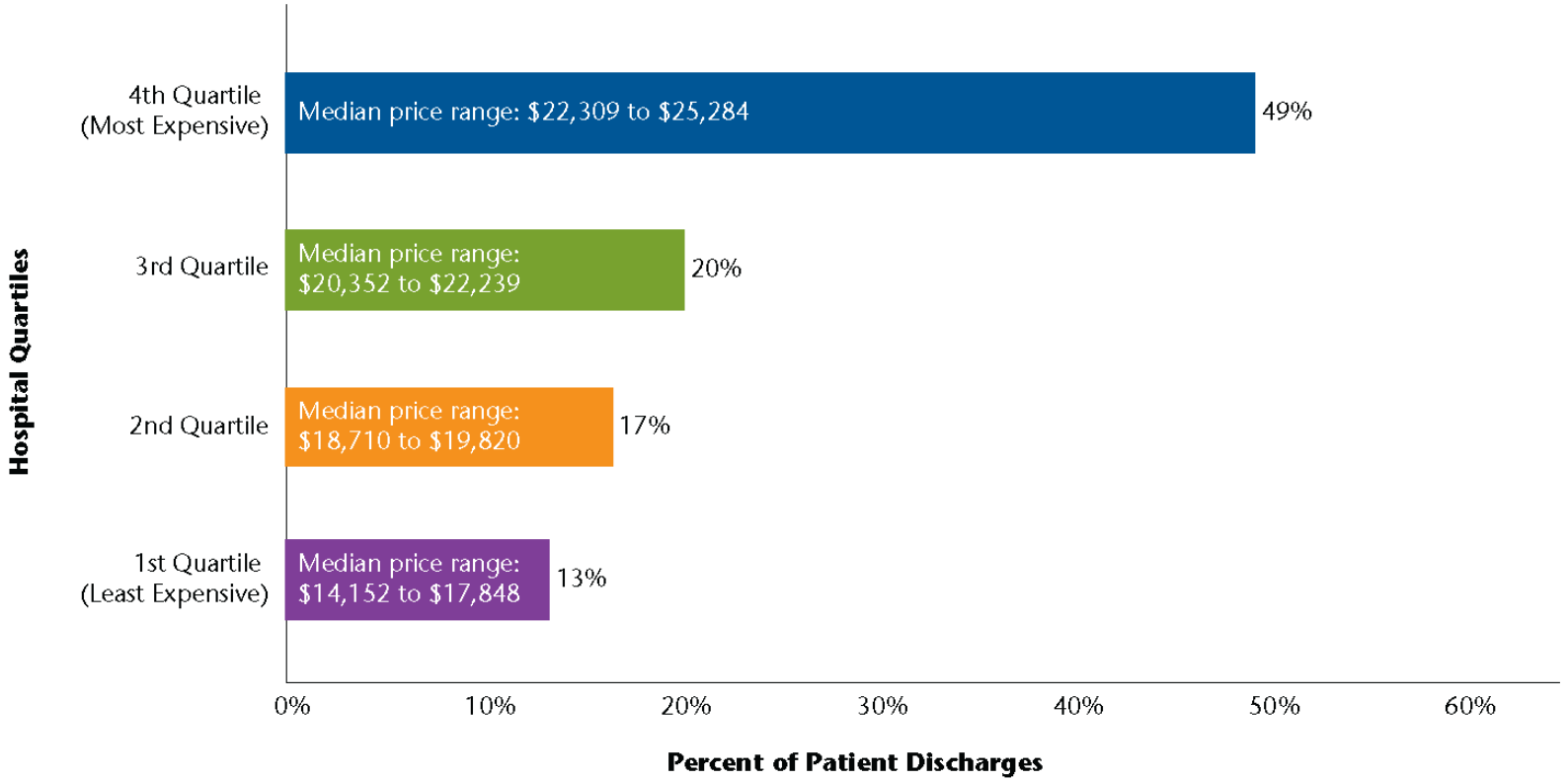
SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Service*s, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Most volume occurred at hospitals in the second most expensive quartile of hospital prices for pneumonia



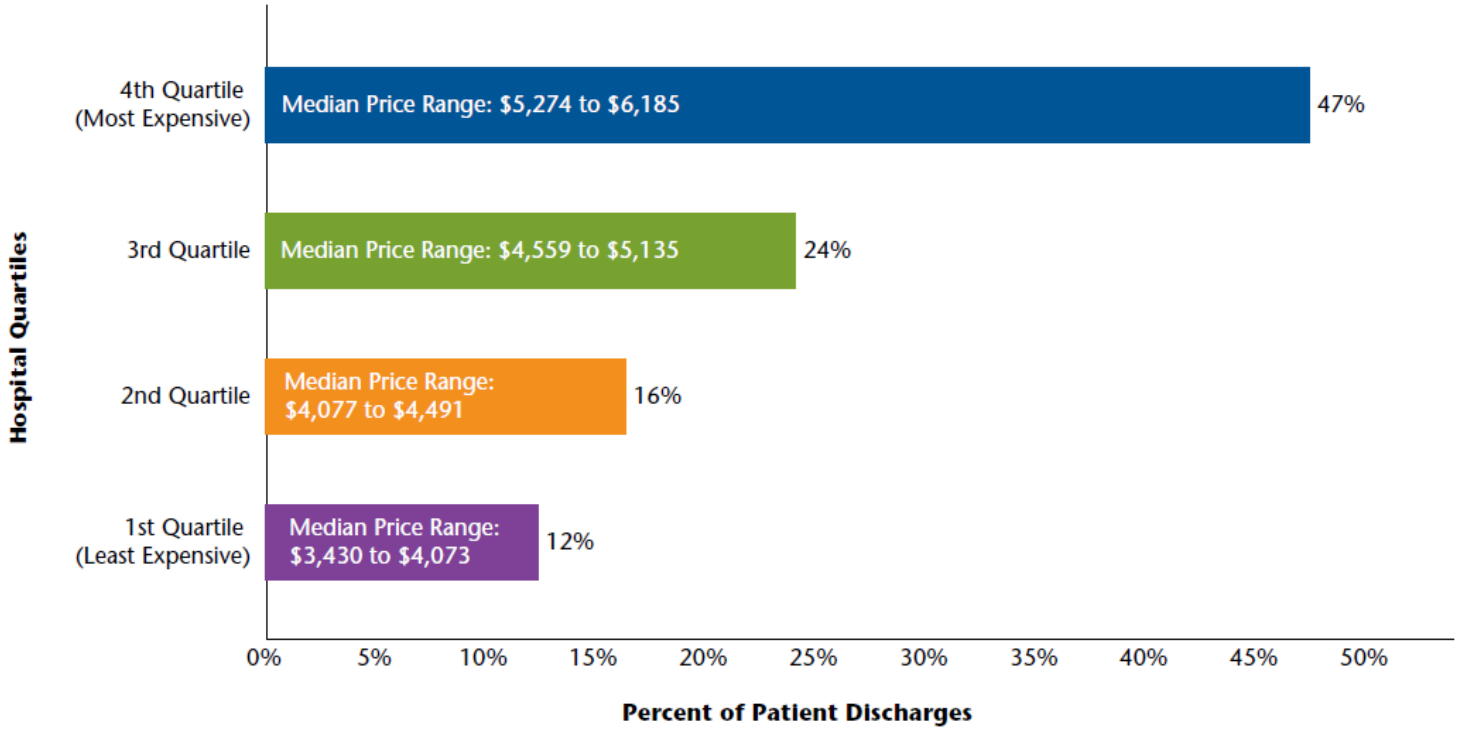
SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Service*s, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Almost half of patient discharges for knee joint replacement occurred at hospitals in the most expensive quartile



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Almost half of patient discharges for vaginal delivery occurred at hospitals in the most expensive quartile



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

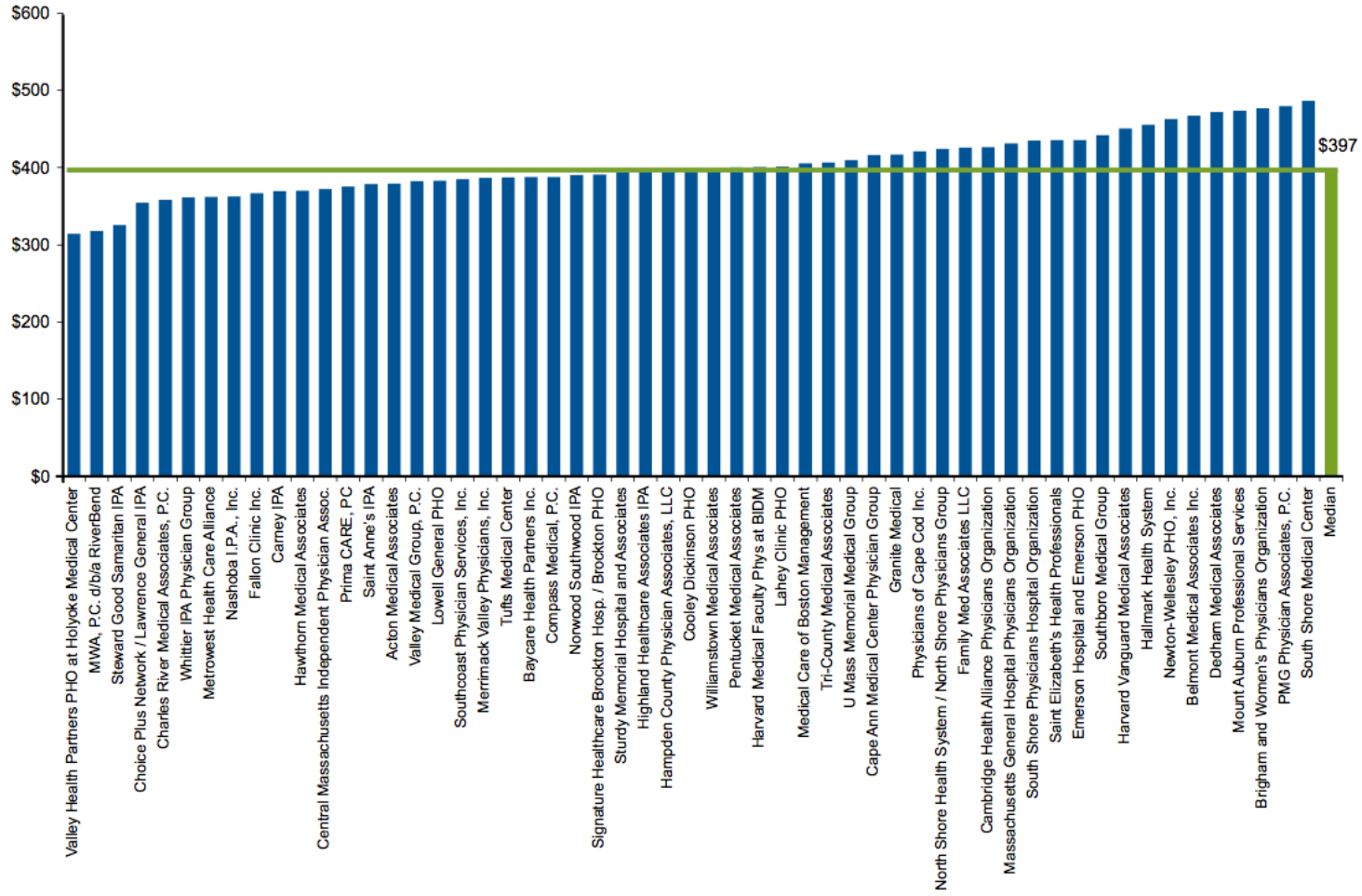
Variation in volume of care provided at providers with low and high levels of health status adjusted total medical expenses

- As part of its recent report on total medical expenses, DHCFP reviewed how member volume is distributed among primary care physician groups with higher or lower health status adjusted total medical expenses across payers.
- DHCFP used median health status adjusted total medical expenses for the groups analyzed within each payer's network to sort physician groups into quartiles. The member volume for each quartile was calculated from the membership reported for each primary care physician group.

Findings:

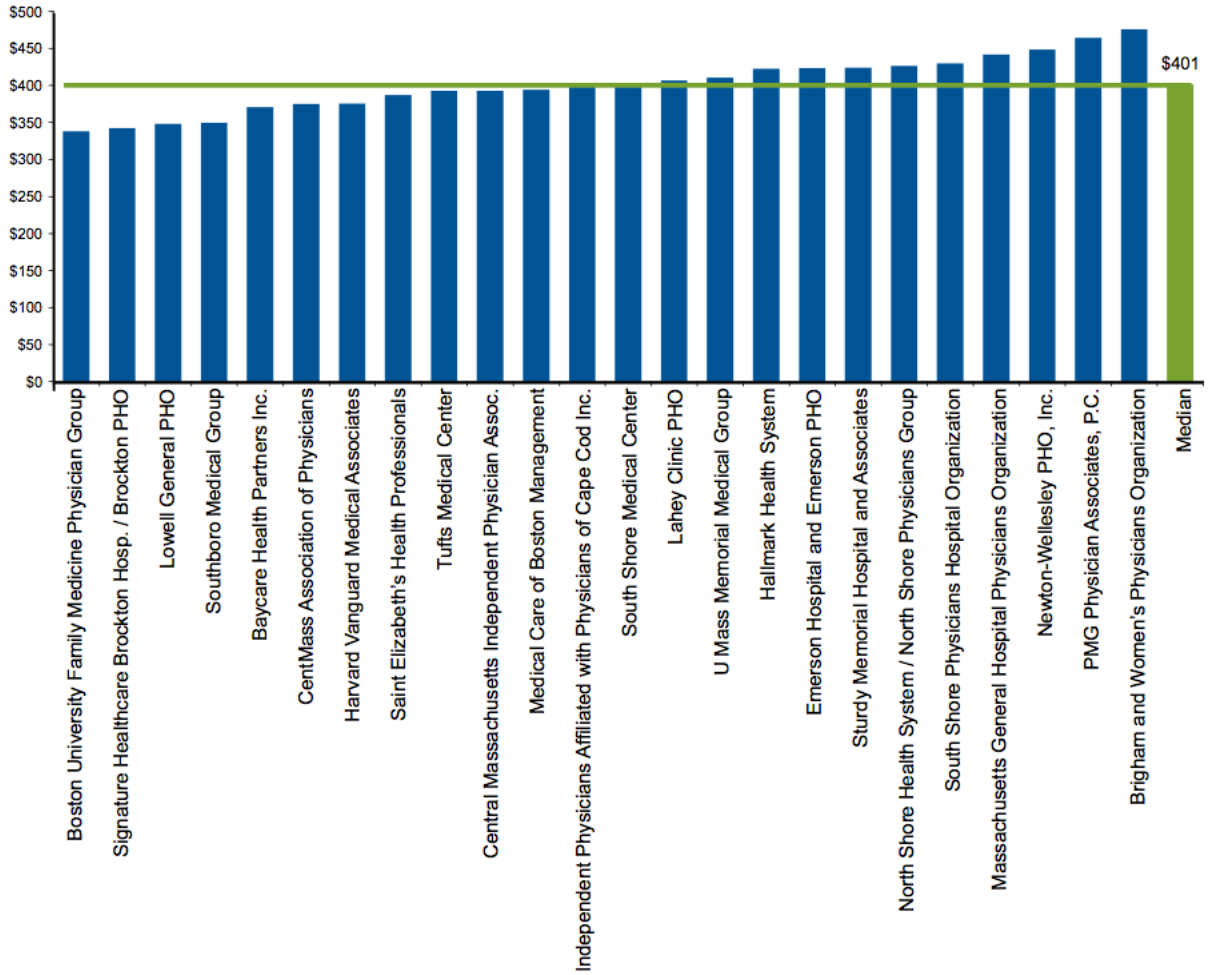
- For some payers, volume is disproportionately concentrated at physician groups with higher health status adjusted total medical expenses.

BCBS Health Status Adjusted Commercial TME by Local Physician Group



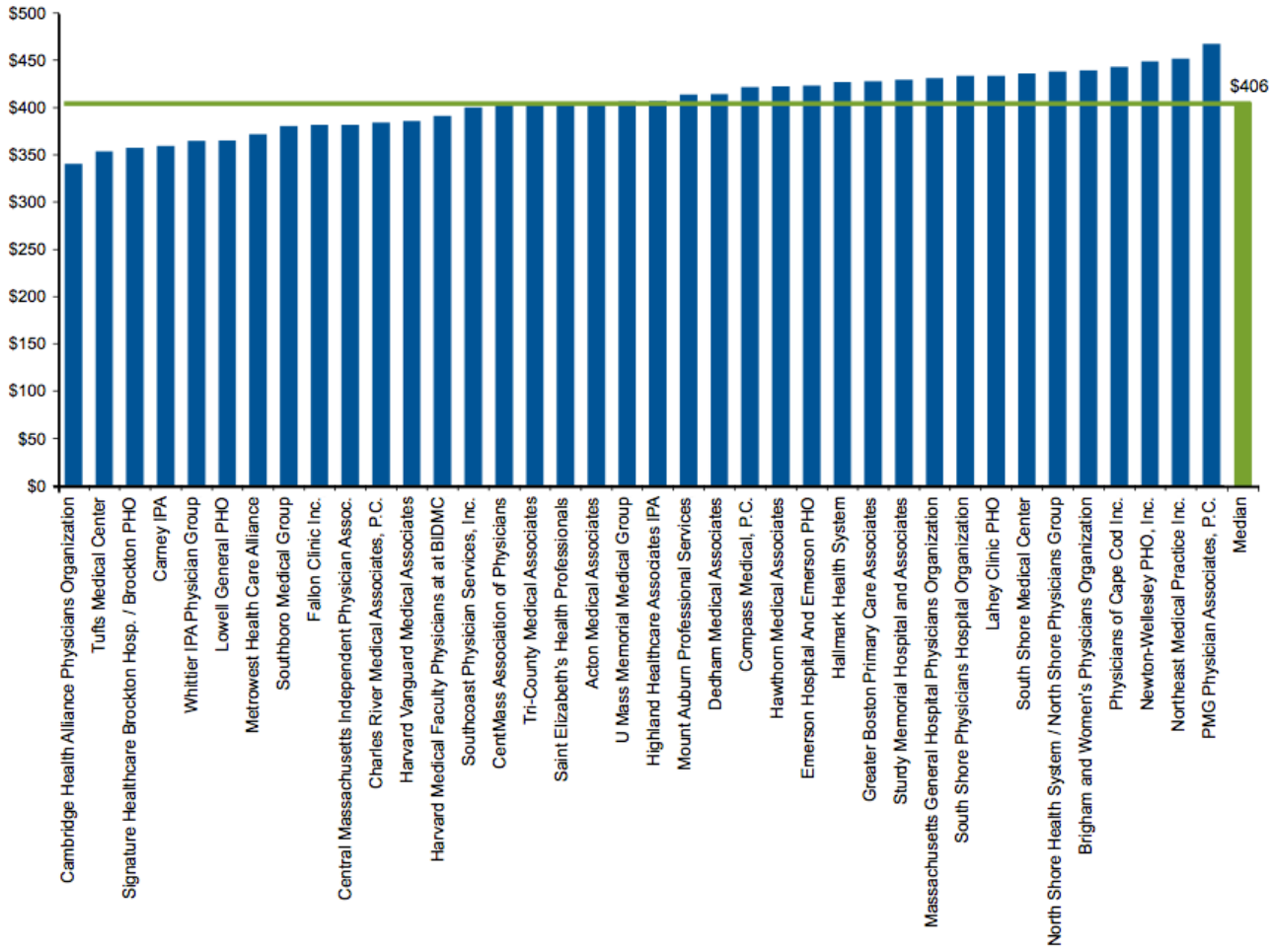
SOURCE: Division of Health Care Finance and Policy, *Massachusetts Total Medical Expenses: 2009 Baseline Report*, June 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/tme_baseline.pdf (last accessed 7/7/2011).

THP Health Status Adjusted Commercial TME by Local Physician Group



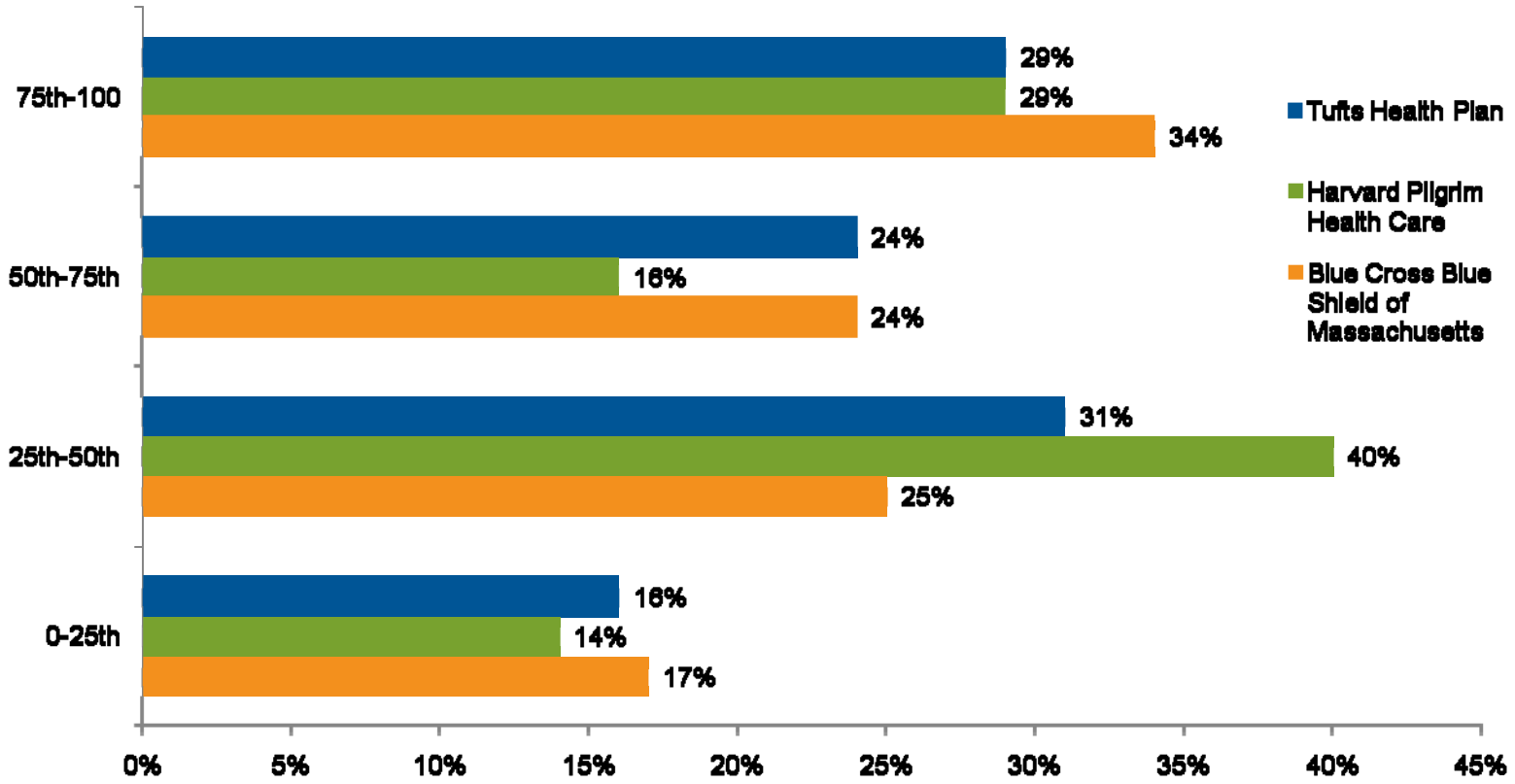
SOURCE: Division of Health Care Finance and Policy, *Massachusetts Total Medical Expenses: 2009 Baseline Report*, June 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/tme_baseline.pdf (last accessed 7/7/2011).

HPHC Health Status Adjusted Commercial TME by Local Physician Group



SOURCE: Division of Health Care Finance and Policy, *Massachusetts Total Medical Expenses: 2009 Baseline Report*, June 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/tme_baseline.pdf (last accessed 7/7/2011).

For 2 of the 3 payers analyzed, member volume was disproportionately concentrated in physician groups with higher health status adjusted total medical expenses



SOURCE: Division of Health Care Finance and Policy, *Massachusetts Total Medical Expenses: 2009 Baseline Report*, June 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/tme_baseline.pdf (last accessed 7/7/2011).

Section 67 of Chapter 288 of the Acts of 2010

- **The commission shall examine:**
- the variation in relative prices paid to providers within similar provider groups;
- the variation in costs of providers for services of comparable acuity, quality, and complexity;
- the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses;
- **the correlation between price paid to providers and**
  - **the quality of care,**
  - **the acuity of the patient population,**
  - **the provider's payer mix,**
  - **the provision of unique services, including specialty teaching services and community services, and**
  - **operational costs, including labor costs;**
- the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and
- policies to promote the use of providers with low health status adjusted total medical expenses.

Correlation Analyses Overview

- The data in this section includes DHCFP and AGO analyses from the 2011 Cost Trends hearings, as well as specific correlation analyses completed for the Special Commission using data submitted by payers in response to the AGO civil investigative demands.

- The analyses are largely based on hospitals, as there is little publically available data to perform the statutorily outlined analysis for physician group practices.

Correlation Analyses Overview

Important Data Caveats:

oMany values are interdependent, e.g. teaching hospitals tend to have higher casemix. This interdependence makes it difficult to infer an effect from a single tested variable, even if the results are statistically significant.

oVarious price measures are used throughout this section which differ in key ways.

- Relative price refers to the "pure price" negotiated between an insurer and provider for a case mix neutral uniform market basket of services. BCBS and THP reported relative price data.
- Relative payment refers to the amount which a provider is paid relative to other providers in an insurer's network. It reflects provider differences in case mix and service mix. HPHC reported relative payment data.
- Actual prices presented are the negotiated severity adjusted prices or price relativities for specific DRGs or procedure codes. They represent only a subset of services provided.

oPayer differences in calculating and reporting the relative price data impact the analytical results, in some cases limiting the analyses that can be completed for that payer.

Correlation Analyses Overview

- Correlation does not imply causation.
- A correlation coefficient measures the strength of relationships between two variables. Values of a correlation coefficient range from -1 to 1.
- R-squared is the square of the correlation coefficient, indicating the extent of the variation in one variable that is related to the variation in the other. Values for R-squared range from 0 to 1, with higher values suggesting a stronger relationship.
- Generally, R-squared values from 0 to 0.3 are considered weak, values between 0.3 and 0.6 are considered moderate, and values above 0.6 are considered strong.
- Statistical significance is also noted. Results that were not statistically significant at p-value <0.05, while presented in the tables, were not deemed meaningful to this analysis.

Correlation between price paid to providers and the quality of care

DHCFP compared price relativities to quality relativities to identify relationships.

- Quality measures were selected specific to each of the 14 DRGs. The selected measures consist of three domains: patient experience, process of care, and outcomes of care. The quality score relies on existing quality measures that are publicly reported, and are directly related to the analyzed DRGs. Quality relativities were created by comparing each hospital's quality score to the average Massachusetts hospital quality score and reporting the ratio.
- The set of quality metrics in this analysis are used in consumer reporting, quality improvement, and pay-for-performance arrangements, though some acknowledge them to be limited in scope and relevance to patient decisions.

Findings:

- There was very little measureable variation in quality among Massachusetts hospitals for the selected 14 DRGs using the available quality metrics.
- For each DRG, there was a significant variation in price that did not relate in any consistent manner to quality metrics.

There is very little measureable variation in quality among Massachusetts hospitals for the 14 selected DRGs

DRG	Composite Quality Relativity	
	Minimum	Maximum
Pneumonia (DRG 139)	0.97	1.03
Chronic obstructive pulmonary disease (DRG 140)	0.92	1.13
Acute myocardial infarction (DRG 190)	0.98	1.04
Congestive heart failure (DRG 194)	0.96	1.04
Appendectomy (DRG 225)	0.96	1.04
Laparoscopic cholecystectomy (DRG 263)	0.96	1.04
Hip joint replacement (DRG 301)	0.96	1.04
Knee joint replacement (DRG 302)	0.96	1.04
Intervertebral disc excision and decompression (DRG 310)	0.96	1.04
Knee and lower leg procedures (DRG 313)	0.96	1.04
Procedures for obesity (DRG 403)	0.96	1.04
Uterine and adnexa procedures for non-malignancy except leiomyoma (DRG 513)	0.96	1.04
Cesarean delivery (DRG 540)	0.97	1.02
Vaginal delivery (DRG 560)	0.94	1.06

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).
Note: The quality relativity is each hospital's composite quality score for the given DRG as it relates to the statewide average composite quality score.

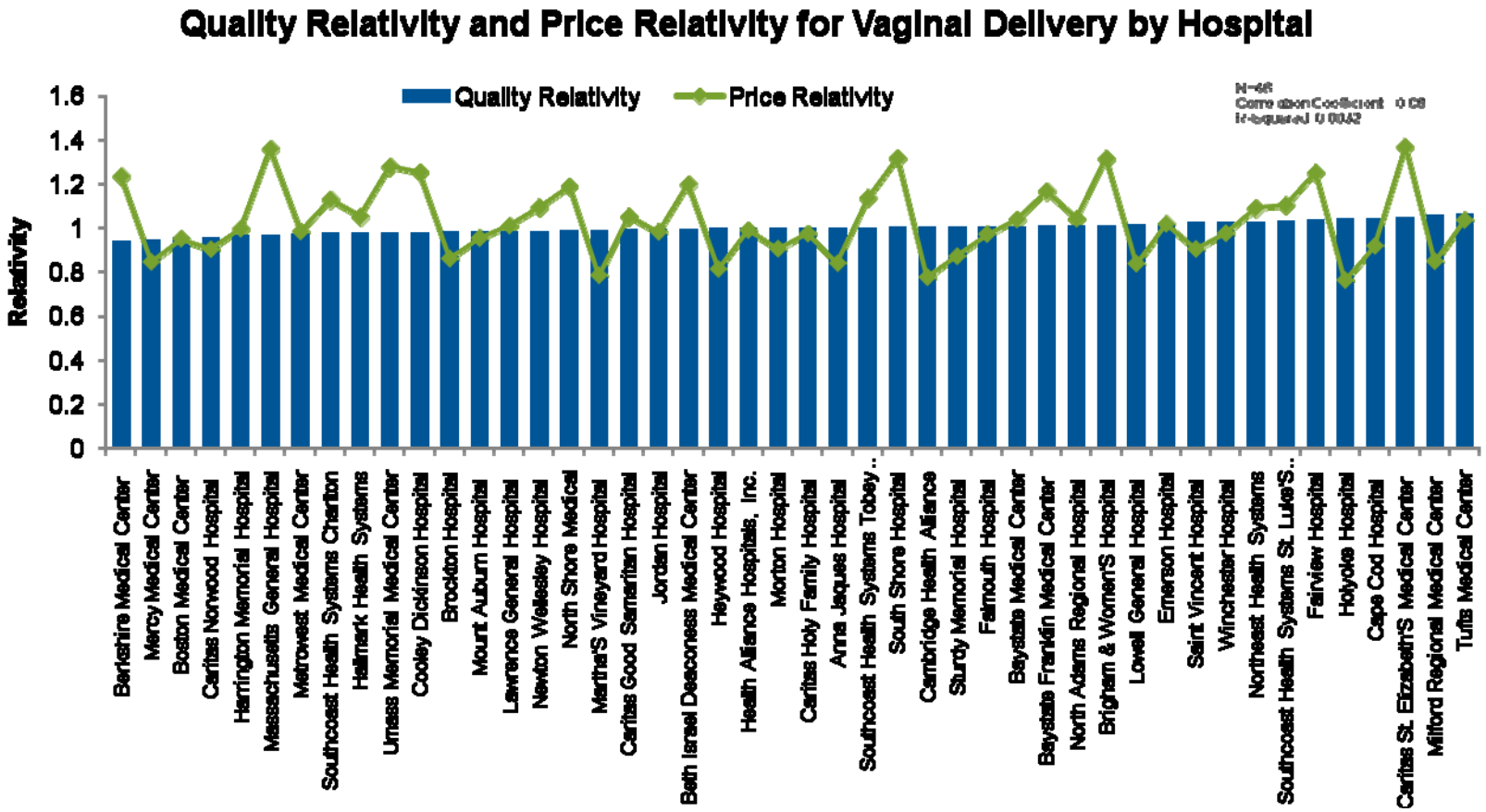
There is no correlation between performance on quality metrics and hospital relative price

	Quality of care	
	N	R^2
Pneumonia	20	0.02
Chronic Obstructive Pulmonary Disease	12	0.00
Acute Myocardial Infarction	7	0.09
Congestive Heart Failure	4	0.57
Appendectomy	24	0.01
Laparoscopic Cholecystectomy	14	0.07
Hip Joint Replacement	12	0.04
Knee Joint Replacement	25	0.01
Intervertebral Disc Excision and Decompression	13	0.12
Knee and Lower Leg Procedures	10	0.16
Procedures for Obesity	20	0.00
Uterine and Adnexa Procedures for Non-Malignancy Except Leiomyoma	19	0.07
Cesarean Delivery	39	0.04
Vaginal Delivery	46	0.00

* Indicates statistical significance at p-value <0.05

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).
Note: The quality relativity is each hospital's composite quality score for the given DRG as it relates to the statewide average composite quality score.

There is no correlation between performance on quality metrics and hospital relative price



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services,* May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).
Note: The quality relativity is each hospital's composite quality score for the given DRG as it relates to the statewide average composite quality score.
The price relativity is the hospital's severity adjusted median price for the given DRG as it relates to the severity adjusted price of the median hospital listed.
Payment methods to hospitals differ, and payers generally do not pay per DRG. For this reason, the comparison above may be limited in reflecting price and quality correlations.

Correlation between price paid to providers and the acuity of the patient population

- Most payment systems in use by payers today adjust for the acuity of a specific case.
  - DRG systems use weighting factors to reflect differing resource needs; some also adjust for severity or differences in resource needs within the DRG.
  - Outpatient systems often use similar weighting factors, although not in all cases.
  - Professional service fee schedules are often based on relative value unit (RVU) systems, that also vary based on time and complexity of the service.
  - DRGs and RVU models may be limited in reflecting actual resource intensity as they do not adjust for socioeconomic status, payer-specific differences, or pediatric patients.
  - There is no widely accepted outpatient measure of patient acuity. The absence of such a measure limits comparisons of outpatient relative prices and acuity.

Correlation between price paid to providers and the acuity of the patient population

- For the 14 selected DRGs, DHCFP examined the differences in prices paid by payers.
- Using the AGO data, DHCFP examined the relationship between a hospital's inpatient relative price and the inpatient casemix index for two payers.

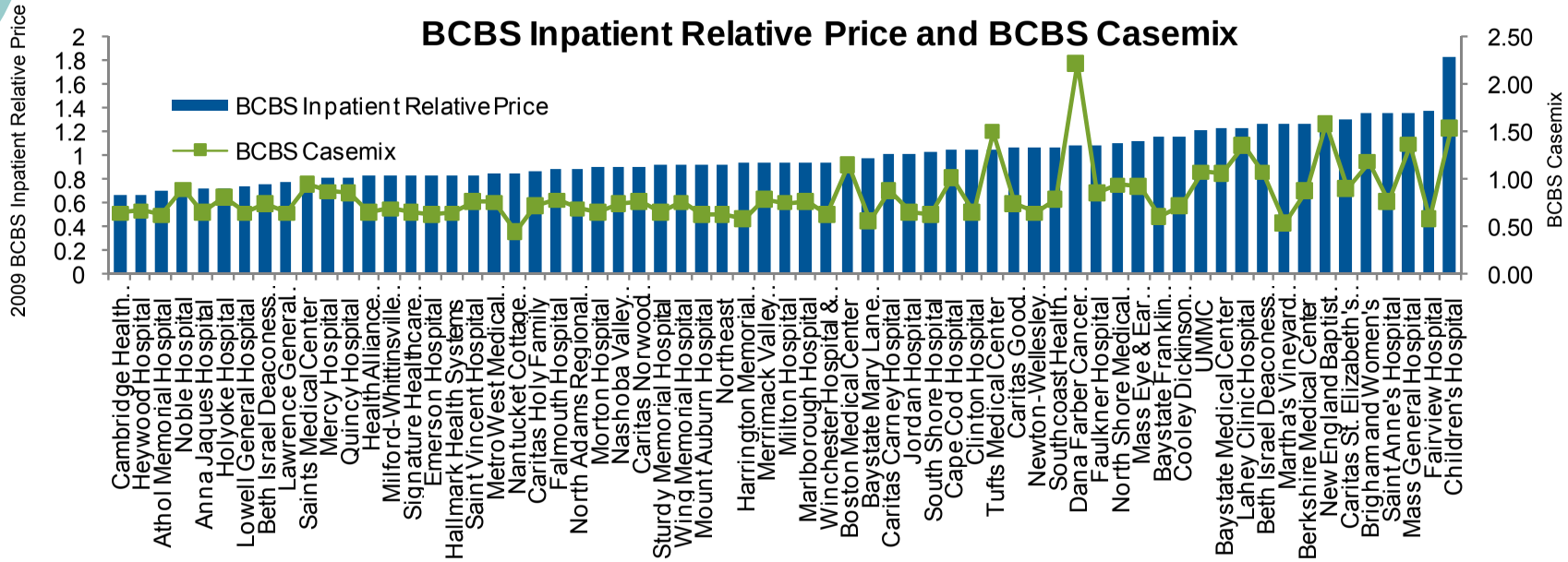
- **Findings:**
  - There is wide price variation within the 14 selected DRGs, even after adjusting for severity.
  - Casemix neutral inpatient relative prices were found to weakly correlate with hospital-specific casemix for BCBS.
  - No correlation was found for THP.
  - The analysis was not conducted for HPHC as that payer did not report independent inpatient price relativities.

- **Comments:**
  - Differences may reflect how well the payer's payment methods account for acuity (e.g. DRG system as compared to per diem method).
  - Results imply that even after adjusting for casemix differences, hospitals with higher acuity may negotiate higher relative prices with BCBS.

Inpatient relative price and casemix index is weakly correlated with price for 1 payer

	R^2, Payer specific casemix index
BCBS inpatient relative price	0.2307*
THP inpatient relative price	0.0248

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Casemix derived using FY2009 hospital discharge data, 3M© All-payer Refined version 26 grouper.
Note: HPHC did not report separate inpatient relative price scores.

Correlation between price paid to providers and the provider's payer mix

- Using the AGO data, DHCFP examined the relationship between a hospital's percentage of private gross revenue and private payer price relativities.

Findings:

- Weak positive relationships were found between the percentage of private gross revenue and the commercial relative prices for two of the three payers analyzed.

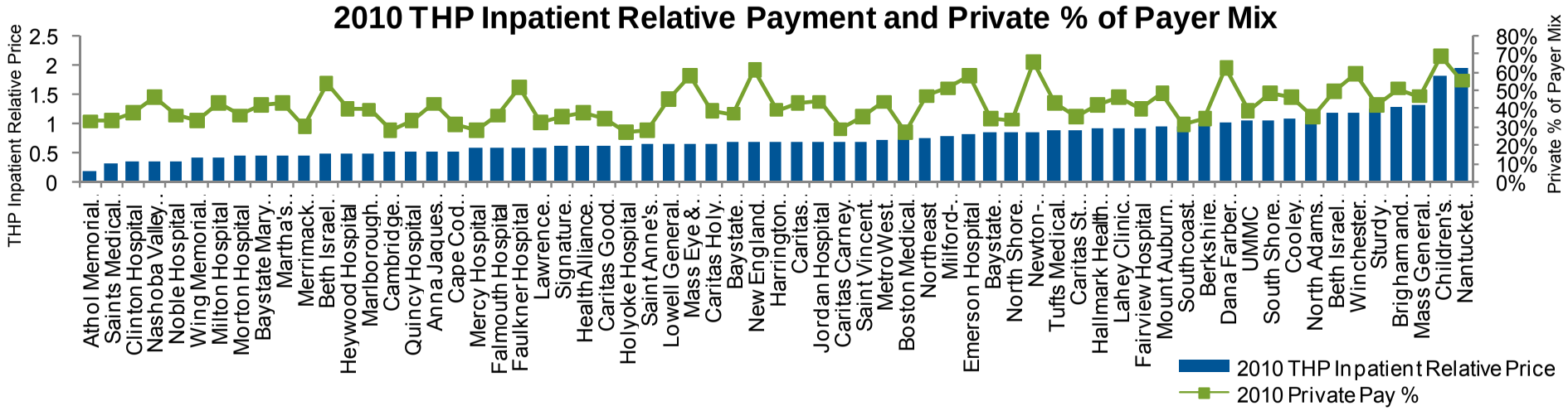
Comments:

- This weak association may reflect the enhanced market leverage of hospitals that serve a higher proportion of privately insured individuals.

Weak relationships were found between private payer mix and relative prices

	R^2, Private % of payer mix
BCBS inpatient relative price	0.1236 *
BCBS outpatient relative price	0.1324 *
THP inpatient relative price	0.2307 *
THP outpatient relative price	0.0999 *
HPHC relative payment (total)	0.0420

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Private payer mix from 2010 DHCFP-403 hospital cost reports.

Correlation between price paid to providers and the provision of specialty services

- Specialty services are provided to relatively few and relatively complex patients. Hospitals that offer these services may receive higher prices to compensate for the cost of providing these services.

- For the purpose of this analysis, the following were considered specialty services:
  - Transplants
  - Burn trauma
  - Neonatal intensive care
  - Oncology only
  - Pediatric only
  - Eye and ear only
  - Orthopedic specialty

Correlation between price paid to providers and the provision of specialty services

- Using the AGO data, DHCFP examined the relationship between a hospital's provision of specialty services and its relative price or payment for each of the three payers.

Findings:

- Weak positive relationships were found between relative prices and the provision of specialty services for two payers.

Comments:

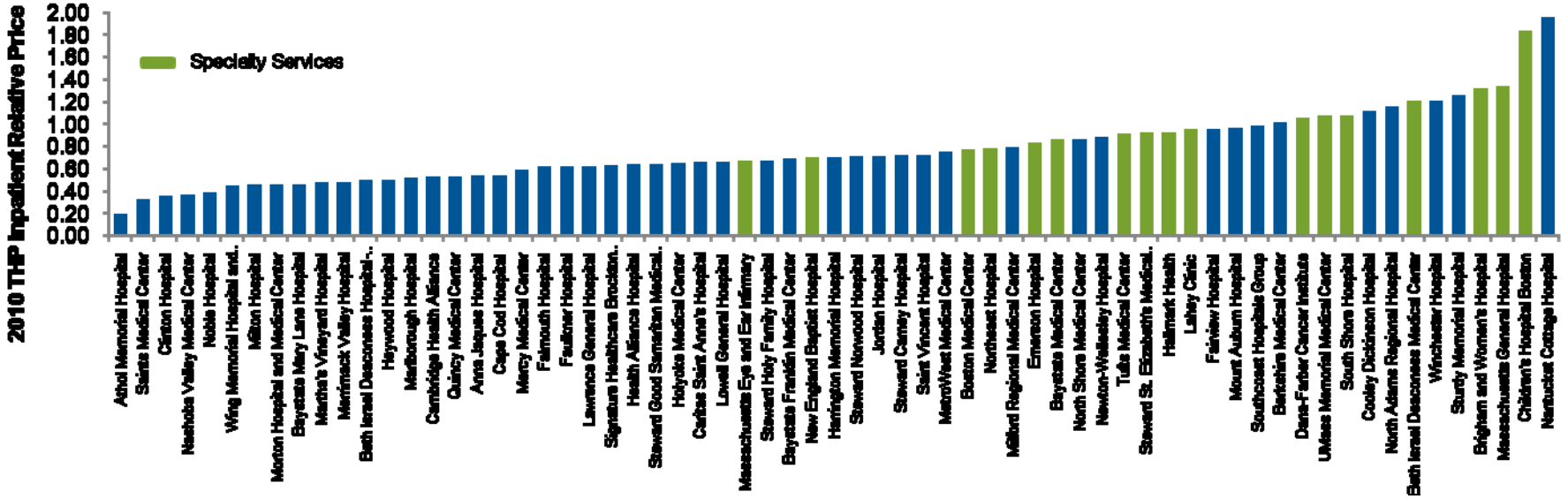
- This may indicate that hospitals that provide specialty services are able to negotiate slightly higher prices.
- However, it is difficult to assess the influence of a single service on the overall relative price.

Weak positive relationships were found between relative prices and the provision of specialty services

	R^2, Provision of specialty services (Y/N)
BCBS inpatient relative price	0.1967*
BCBS outpatient relative price	0.0423
THP inpatient relative price	0.2050*
THP outpatient relative price	0.0171
HPHC relative payment (total)	0.0061

* Indicates statistical significance at p-value <0.05

2010 THP Inpatient Relative Payment and Provision of Specialty Services



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding provision of specialty services from 2010 DHCFP-403 hospital cost reports.

Correlation between price paid to providers and the provision of community services

- DHCFP defined community services as services with lower acuity. These services often receive lower reimbursements.

- For the purpose of this analysis, the following were considered community services:
  - Psychiatry
  - Substance abuse
  - Detoxification
  - Addiction recovery

Correlation between price paid to providers and the provision of community services

- Using the AGO data, DHCFP examined the relationship between a hospital's provision of community services and the relative price or payment for each of the three payers.

Findings:

- No statistically significant relationship was found for any payer between relative prices and the provision of community services.

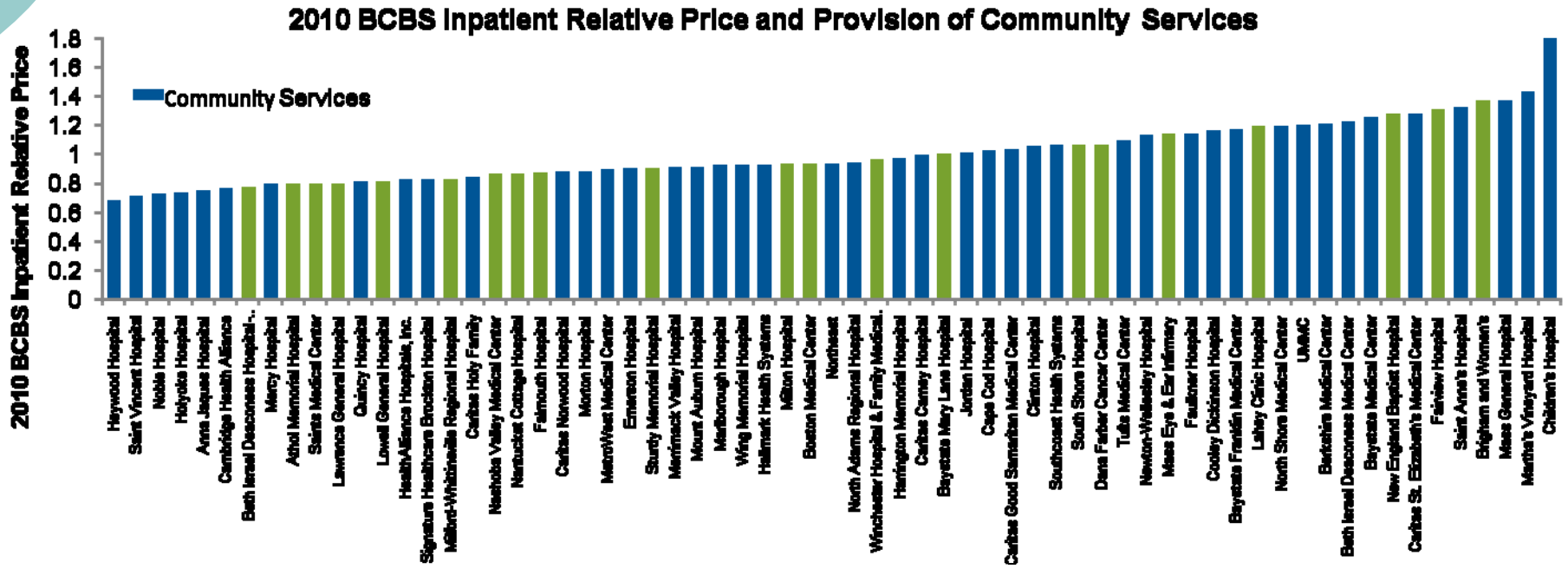
Comments:

- As community services are broadly available from both teaching and community hospitals, the lack of correlation is not surprising.
- It is difficult to assess the influence of a single service on the overall relative price.

No meaningful relationship was found between relative prices and the provision of community services

	$R^{2,}$ Provision of community services (Y/N)
BCBS inpatient relative price	0.0260
BCBS outpatient relative price	0.0189
THP inpatient relative price	0.0031
THP outpatient relative price	0.0062
HPHC relative payment (total)	0.0032

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding provision of community services from 2010 DHCFP-403 hospital cost reports.

Correlation between prices paid to providers and operational costs

- Using data submitted by payers to the AGO as part of 2011 Cost Trends, DHCFP compared the average inpatient cost per casemix-adjusted discharge (CMAD) and the inpatient relative prices for two payers.

Findings:

- There were weak positive correlations between costs per CMAD and inpatient relative price.

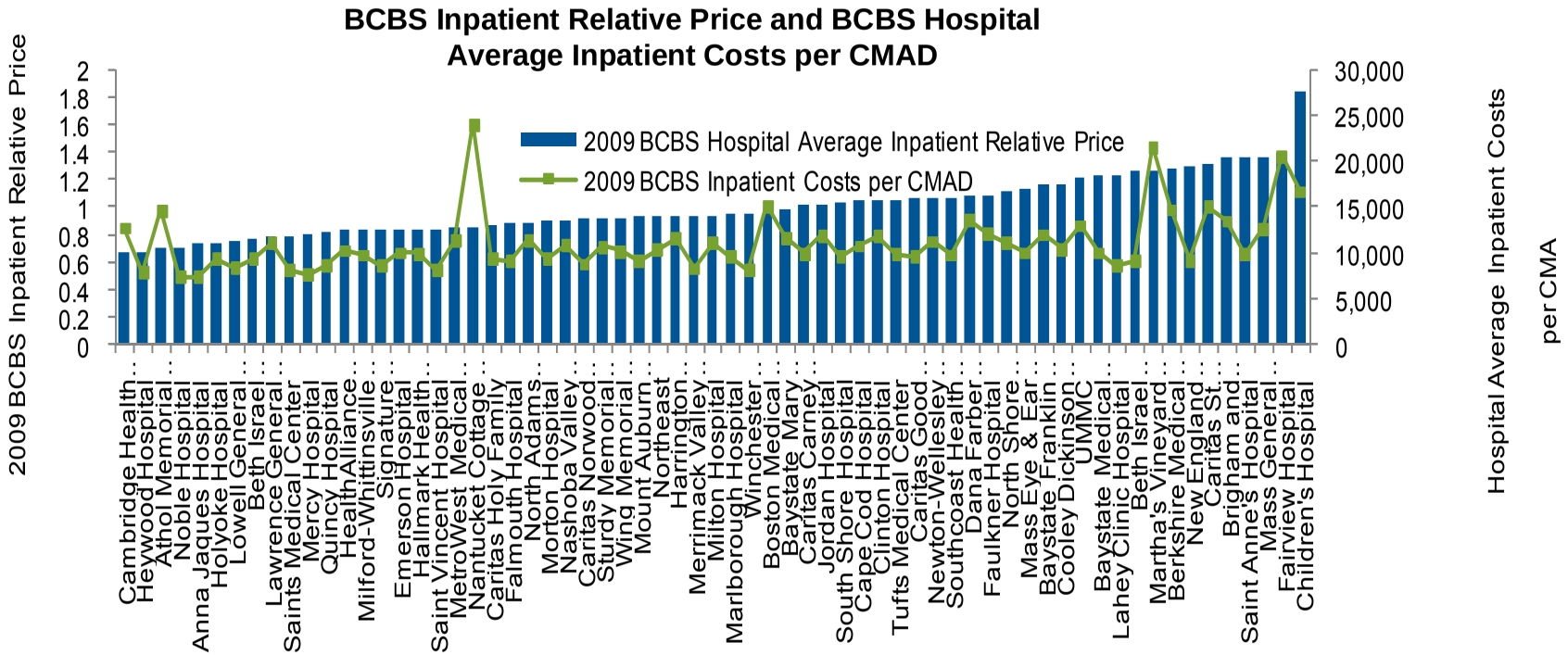
Comments:

- Suggests that higher cost hospitals tend to negotiate higher relative prices.
- Further analysis using actual claims-based cost and price data may allow for more robust findings.

Costs per CMAD and inpatient relative price are weakly correlated for two payers

	R^2, Hospital average inpatient cost per CMAD, by payer
BCBS inpatient relative price	0.1789*
THP inpatient relative price	0.1572*

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding inpatient cost per CMAD from 2009 DHCFP-403 hospital cost reports.

Section 67 of Chapter 288 of the Acts of 2010

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- the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses;
- the correlation between price paid to providers and
  - the quality of care,
  - the acuity of the patient population,
  - the provider's payer mix,
  - the provision of unique services, including specialty teaching services and community services, and
  - operational costs, including labor costs;
- **the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and**
- policies to promote the use of providers with low health status adjusted total medical expenses.

Correlation between price paid to providers and status as a disproportionate share hospital

- Disproportionate share hospitals (DSH) are hospitals with a relatively higher proportion of public payers.
- DSH hospitals are defined differently in state and federal law.
  - Under MGL c. 118G, DSH hospitals are defined as any acute hospital with a minimum payer mix of 63% attributable to Medicare, Medicaid, other government payers, and free care.
  - Federal law considers the proportion of patient days attributable to patients with Medicare Part A and Supplemental Security Income (SSI), and to patients eligible for Medicaid, but not eligible for Medicare Part A.

Note: A hospital will receive additional Medicare payments if they meet specific thresholds, depending on the number of beds and the facility's location in an urban or rural area. See http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp.

Correlation between price paid to providers and status as a disproportionate share hospital

- Using AGO data, DHCFP compared the following factors with the price relativities for the three payers:
  - Massachusetts designation as a DSH hospital;
  - DSH percent, using the state definition; and
  - DSH percent, using the Medicare definition (derived from 2007 data).

Findings:

- Weak *negative* correlations were found among the above three factors and the commercial relative prices for each of the three payers.

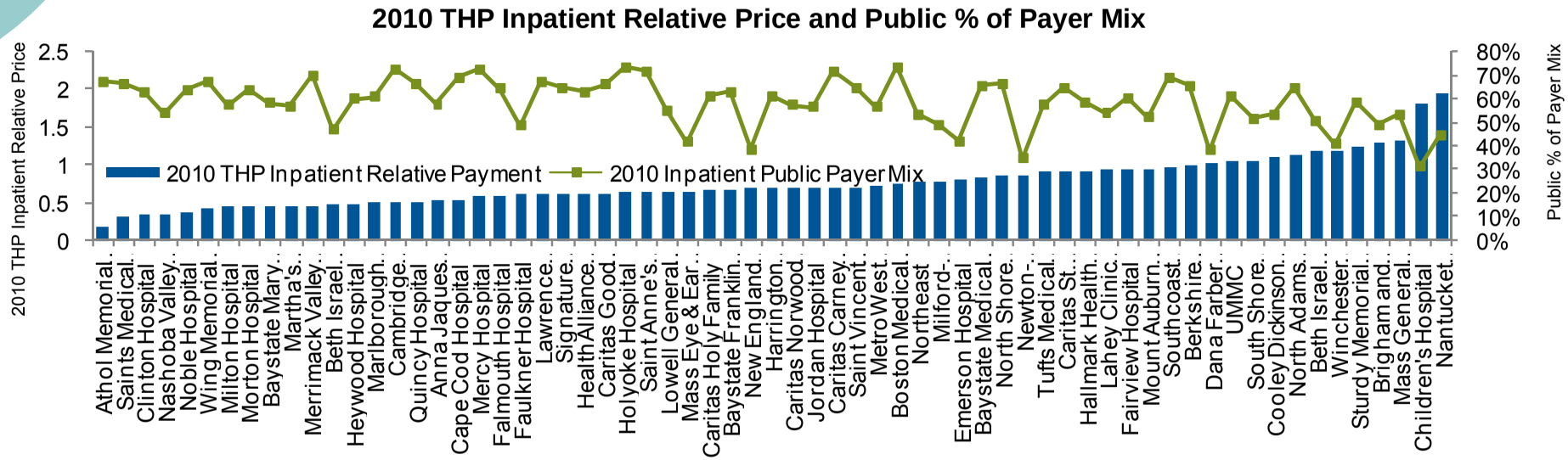
Comments:

- Findings suggest that hospitals that are largely dependent on public payers are slightly more likely to have lower private relative prices.

Weak *negative* correlations were found among various DSH measures and the commercial relative prices for each of the 3 payers

	R^2, Public % of payer mix	R^2, State DSH (Y/N)	R^2, Medicare DSH %
BCBS inpatient relative price	0.1236 *	0.0386	0.0288
BCBS outpatient relative price	0.1324 *	0.0596	0.1327 *
THP inpatient relative price	0.2307 *	0.0944 *	0.0184
THP outpatient relative price	0.0999 *	0.0373	0.1378 *
HPHC relative payment (total)	0.0420	0.0224	0.0929 *

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding public payer mix and Medicare DSH percentage from 2010 DHCFP-403 hospital cost reports.

Correlation between price paid to providers and status as an academic teaching hospital

- Hospitals with graduate medical education programs assume additional costs associated with teaching medical residents.
- Using data submitted by payers to the AGO as part of the 2011 Cost Trends, DHCFP compared the following factors with the price relativities for the three payers:
  - Designation as a teaching hospital; and
  - Ratio of residents per 100 beds.

Findings:

- There was no statistically significant correlation between the ratio of residents to beds and relative prices.
- For two of the three payers, weak positive correlations were found between the inpatient relative prices and a hospital's designation as a teaching hospital.
- There was no statistically significant correlation between the two factors and outpatient relative prices for any of the three payers.

Comments:

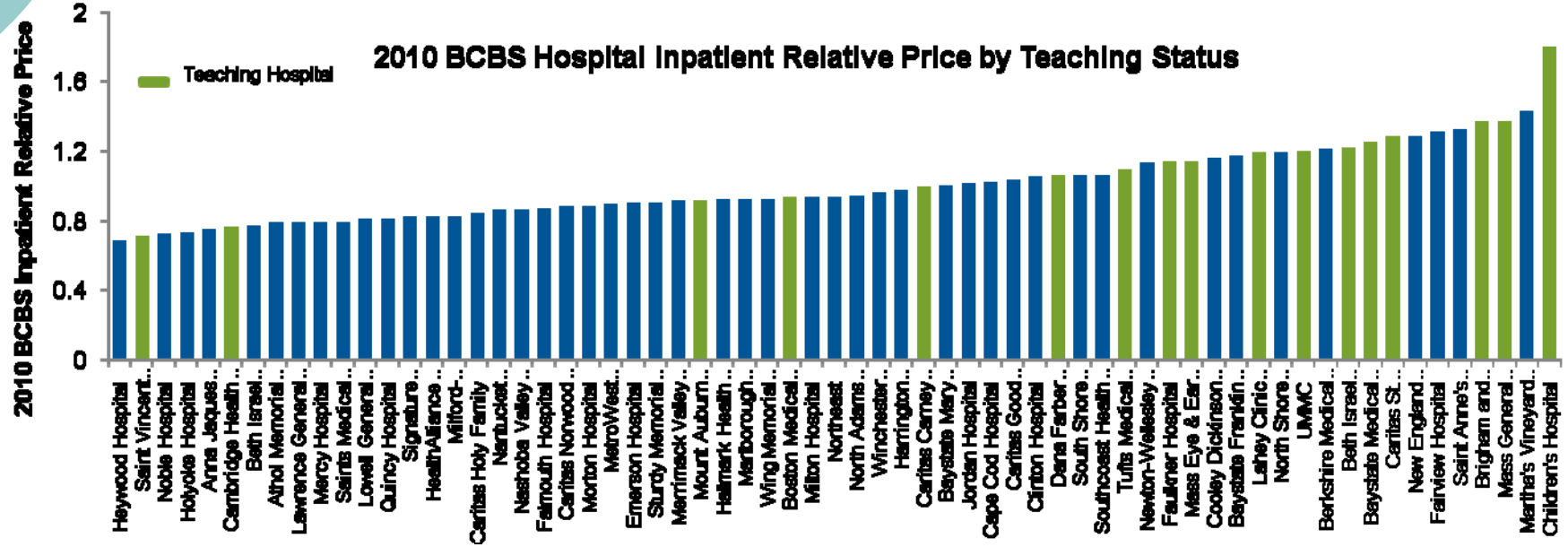
- Findings suggest that teaching hospitals are associated with slightly higher prices.
- May indicate that payers make additional payments for inpatient services to teaching hospitals.

Note: In this analysis, the Division of Health Care Finance and Policy defined teaching hospitals according to the Medicare Payment Advisory Commission's (MedPAC) definition of a major teaching hospital: at least 25 full-time equivalent medical school residents per one hundred inpatient beds.

Teaching status is weakly correlated with inpatient price for two payers

	$R^{2,}$ Teaching Status (Y/N)	$R^{2,}$ Ratio of FTE residents : 100 beds
BCBS inpatient relative price	0.1809 *	0.0184
BCBS outpatient relative price	0.0322	0.0319
THP inpatient relative price	0.1364 *	0.0302
THP outpatient relative price	0.0111	0.0004
HPHC relative payment (total)	0.0007	0.0094

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding FTE residents per 100 beds from 2010 DHCFP-403 hospital cost reports.

Additional Price Analyses

Additional Price Analyses

- Additional analysis was completed to help inform the discussions on price variation. Included in this section:
  - Examination of public payer price variation
  - Examination of role of volume on price variation
  - Multiple regression models to assess the explanatory effect of the considered factors

Public Payer Price Variation

- Prices paid by Medicare and Medicaid also vary, but the variations are formula-driven and transparent.
- Medicare's inpatient method for most acute hospitals uses a national base rate and uniform DRG weights. Payments to individual hospitals vary based on adjustments to the national base rates for:
  - Regional variation (i.e. wage index)
  - Teaching status
  - Disproportionate share status
  - Additional exceptions, such as outlier payments
- MassHealth has standard payment methods for hospital inpatient and outpatient services, with adjustments for hospital-specific casemix and wage adjustments, plus some hospital-specific costs.
- Medicare's physician fee schedule adjusts for regional variation; MassHealth has a single uniform fee schedule for physicians.

Public Payer Price Variation: Medicare

- Analysis of Medicare hospital prices revealed inpatient price variation that ranged from 0.86 to 1.64, a range comparable to that observed for private payers.

- Although there was a similar range of variation, the ranking of hospitals between Medicare and private payer prices was not similar.

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services,* May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Public Payer Price Variation: Medicare
Pneumonia

Hospital	Medicare Rank	Private Payer Rank (DRG 139)	Medicare Price Relativity	Private Payer Price Relativity (DRG 139)
Boston Medical Center	1	31	1.64	0.95
Tufts Medical Center	2	20	1.53	1.03
Beth Israel Deaconess Medical Center	3	8	1.45	1.2
Caritas St. Elizabeth's Medical Center	4	1	1.42	1.37
Brigham & Women's Hospital	5	4	1.37	1.31
U Mass Memorial Medical Center	6	5	1.36	1.28
Cambridge Health Alliance	7	43	1.33	0.77
Massachusetts General Hospital	8	2	1.32	1.36
Baystate Medical Center	9	19	1.22	1.03
		.....		
Jordan Hospital	36	26	0.92	0.98
Sturdy Memorial Hospital	37	36	0.92	0.87
South Shore Hospital	38	3	0.92	1.32
Caritas Norwood Hospital	39	35	0.92	0.9
Baystate Franklin Medical Center	40	10	0.91	1.17
Winchester Hospital	41	27	0.89	0.97
Emerson Hospital	42	21	0.88	1.01
North Adams Regional Hospital	43	18	0.87	1.04
Cooley Dickinson Hospital	44	6	0.86	1.25
Correlation Coefficient on Ranks		**0.323**		
R-squared		**0.105**		

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

MassHealth hospital prices vary across DRGs, but the variation is less than private payers

Diagnostic-Related Group	Payer Risk-Adjusted Median Price		Price Relativity		Variance between min and max
	Minimum	Maximum	Minimum	Maximum	
Pneumonia	$4,182	$4,955	0.94	1.12	19%
Chronic obstructive pulmonary disease	$4,233	$4,901	0.97	1.12	16%
Acute myocardial infarction	$4,977	$6,918	0.83	1.15	39%
Congestive heart failure	$5,589	$6,005	0.98	1.05	7%
Appendectomy	$5,616	$7,590	0.91	1.23	35%
Laparoscopic cholecystectomy	$6,552	$7,268	0.98	1.08	11%
Hip joint replacement	$13,011	$14,192	0.98	1.07	9%
Knee joint replacement	$11,556	$13,145	0.94	1.07	14%
Intervertebral disc excision and decompression	$5,584	$6,517	0.94	1.09	17%
Knee and lower leg procedures	$7,853	$9,698	0.89	1.10	24%
Procedures for obesity	$8,451	$10,125	0.91	1.08	20%
Uterine and adnexa procedures for non-malignancy except leiomyoma	$5,350	$6,276	0.96	1.13	17%
Cesarean delivery	$5,710	$7,339	0.91	1.17	29%
Vaginal delivery	$3,762	$5,093	0.91	1.23	35%

SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Price Variation in Massachusetts Health Care Services,* May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 7/7/2011).

Role of Volume on Price Variation

- For each hospital, DHCFP conducted a correlation analysis between inpatient price and the percent of statewide all-payer discharges.

Findings:

- There was a weak correlation between price and volume.

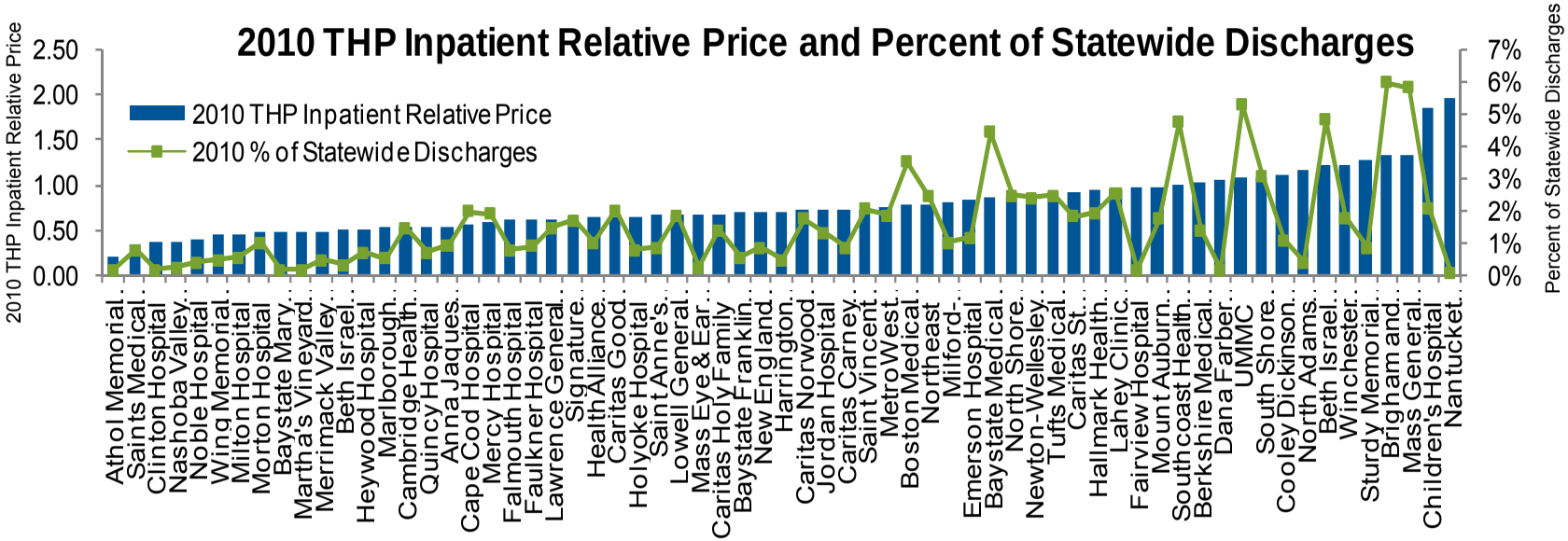
Comments:

- Higher volume hospitals may be able to command higher prices during negotiations with private payers due to their larger market shares.

Hospital volume is weakly correlated with private payer prices

	R^2, % of Statewide Discharges
BCBS inpatient relative price	0.1415*
THP inpatient relative price	0.1966*

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding volume from 2010 DHCFP-403 hospital cost reports.

Regression Analyses

- DHCFP completed multiple regressions for each of the three payers using the following variables:
  - Teaching status (0,1)
  - Public payer mix (% of total revenue)
  - Payer-specific casemix index (inpatient relative price/payment only)
  - Inpatient cost per case mix adjusted discharge (inpatient relative price/payment only)
- Because a low number of beds may skew certain ratios, hospitals with less than 40 beds were excluded.

Regression Analyses Parameter Estimates for Statistically Significant Variables

- Public payer mix was the most consistently significant variable across payers.
- For every one percent increase in a hospital's revenue share from public payers, its relative price scores decreased by 0.44 and 1.03 percentage points (or between 0.44% and 1.03%).
- For every $1,000 increase in inpatient costs per adjusted discharge, BCBS and THP inpatient relative prices and payments, respectively, increased by 0.05 points (or increased by 5%).

	R^2 (Adj.R^2)	Model Intercept	Teaching Status	Public Payer Mix	Case mix Index	Inpatient Costs per CMAD (per $1000)
BCBS Inpatient (2009)**	.6281 (.6010)	0.4265	0.0126	**-.4413***	**.4015****	**0.0468****
BCBS Outpatient (2009)*	.1683 (.1392)	1.4064	0.1348	**-.8361***	N/A	N/A
THP Inpatient (2009)**	.3651 (.3189)	0.8732	0.1615	**-1.030***	-.0327	**0.0498***
THP Outpatient (2009)*	.1161 (.0851)	1.3677	0.1421	-.8052	N/A	N/A
HPHC Blended (2009)*	.1470 (.1171)	1.2883	0.0952	**-.7315***	N/A	N/A

* Indicates statistical significance at p-value <0.05, ** at p <.0001

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding teaching status, public payer mix, provision of specialty services, casemix, inpatient cost per CMAD, and discharges from 2009 DHCFP-403 hospital cost reports. N=60 for all models.

Price Variation Analyses: Summary of Findings

- Although some weak and moderate correlations were found, none of the factors analyzed were independently found to be significant predictors of higher or lower provider prices.

- By combining some variables, most notably payer mix, casemix, and inpatient costs, price variation may be partially explained. However, a significant amount of unexplained variation exists.

- In the absence of quantifiable relationships, it is reasonable to conclude that prices appear to be strongly influenced by other unexamined factors.

Other potential reasons for price variation as identified in literature

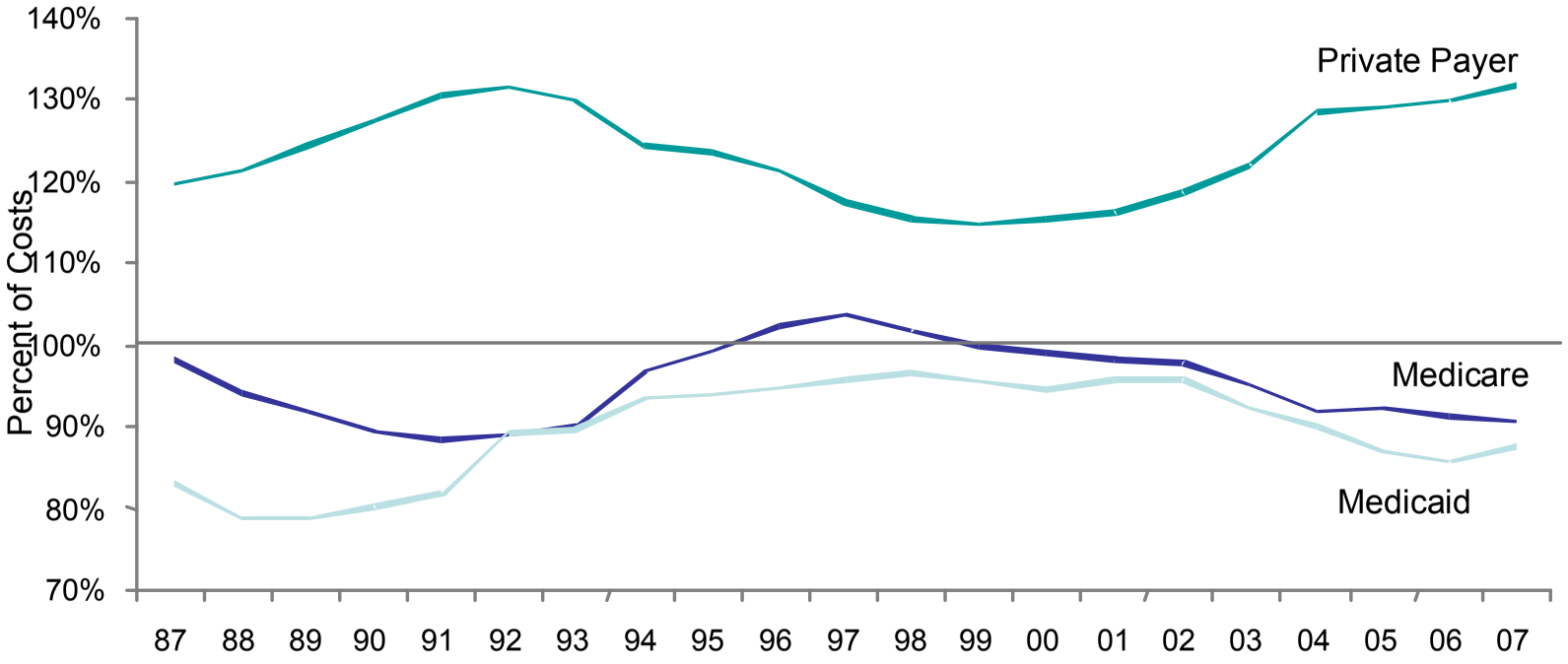
- Cost-shifting
- Market Power
- Reputation
- Differential Pricing

Cost-shifting

- Theory of providers covering a shortfall from public payers by raising prices for other purchasers – mainly private insurers.
- A 2008 joint insurer and hospital-funded study estimated that cost-shifting adds over $1,000 to the annual premiums of a family of four.
  - Report defined cost-shifting as the difference in operating margin between public and private payer business for providers.

SOURCES: Reinhardt 2006; Fox 2008

U.S. Hospitals Shift Costs to Private Payers, 1987-2007



Note: Medicaid payments include Medicaid Disproportionate Share payments.
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2007, for community hospitals in AHA Chartbook: Trends affecting hospitals and health systems, 2009.

Cost-shifting

- Independent analysis reports a limited relationship:
  - "Most of the analyses and commentary…provide a false impression that cost shifting is a large and pervasive phenomenon…cost shifting can and has occurred, but usually at a relatively low rate."
  - Cost shifting is "relatively minor."
  - One Massachusetts insurer: "We do look at payer mix too, but it doesn't have a huge effect."

SOURCES: Frakt 2011, Congressional Budget Office 2008, insurer 2011

Market Power

- MedPAC found that hospitals with substantial negotiating leverage can allow unit costs to rise because they can obtain higher private insurance rates to offset negative Medicare margins that result from their high costs.
- A study of insurer payment rates in eight markets concluded "few would characterize the variation in hospital and physician payment rates found in this study to be consistent with what would be expected in a highly competitive market…Indeed, observers of markets outside of health care would be stunned by the degree of price variation."

SOURCE: MedPAC 2009; Ginsburg 2010

Market Power

- Metro areas with the least competition had hospital prices 18 percent higher and physician prices that were 11 percent higher than areas with the most competition.
- Hospital prices in concentrated markets were between 13-15% higher for certain services than were prices in competitive markets.
- Hospitals affiliated with either of the two health care systems in Rhode Island were compensated at 149% and 117% of Medicare, whereas unaffiliated hospitals were paid at an average of 97% of Medicare.

SOURCE: GAO, 2005; RI Office of Health Insurance Commissioner, 2010, Robinson, 2011

Reputation

- High-ranked hospitals can gain market share by recruiting physicians, other staff and patients based on reputation.
- Some hospitals are so highly regarded that consumers perceive any network that excludes these "must-have" hospitals as undesirable
- Hospitals ranked on the "America's Best Hospitals" list, which relies significantly on subjective assessments for reputation, have been shown to have a 5% increase in non-emergency patient volume with increases in ranking.

SOURCE: Ginsburg 2010; Pope, 2006

Differential Pricing

- Theory of charging different customers different prices for the same service.
- “Price discrimination is a perfectly natural phenomenon in any health system not subject to price regulation.”

SOURCE: Reinhardt, 2006

Next Steps: Meeting 3

- Review of current market activity to address variation in provider prices
- Discussion of the impact of payment reform
- Review of possible strategies to reduce price variation

HEALTH CARE DIVISION PRESENTATION TO PROVIDER PRICE REFORM COMMISSION:

FINDINGS FROM ATTORNEY GENERAL'S EXAMINATIONS OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
ONE ASHBURTON PLACE • BOSTON, MA 02108

July 13, 2011

VARIATION IN PROVIDER PRICES

1. What type of variation exists in the commercial prices paid by insurers to providers?
2. Are those variations adequately explained by value-based differences in the services provided?
3. How are variations in prices paid related to overall health care costs?
4. How are variations in prices related to payment methodology?

MEASURING HEALTH CARE COSTS

- TOTAL MEDICAL EXPENSES (TME): The total cost of all the care that a patient receives, including the payments by the health plan for the care of the patient, and any copayment or deductible for which the patient is responsible. TME reflects *both* price of services and volume of services.

- PRICE: The contractually negotiated amount that an insurance company pays a health care provider for providing health care services; we reviewed relative price information, which shows the prices paid by health plans to providers for all services in aggregate as compared to other providers in the health plan network.

RELATIVE PRICE vs. RELATIVE PAYMENT

- RELATIVE *PAYMENT*: Payments made by insurers to providers in their network, as compared to the network-wide average; relative payments reflect the volume, product mix, service mix, and/or other factors particular to a provider's payment history.

- RELATIVE *PRICE*: Prices set between insurers and providers in their network, as compared to the prices paid to other providers for the same comprehensive bundle of services; relative prices do not reflect the insurance product mix, service mix, or other factors that are particular to an individual providers' payment history.

THERE IS WIDE VARIATION IN PRICES IN EACH MAJOR INSURER'S NETWORK

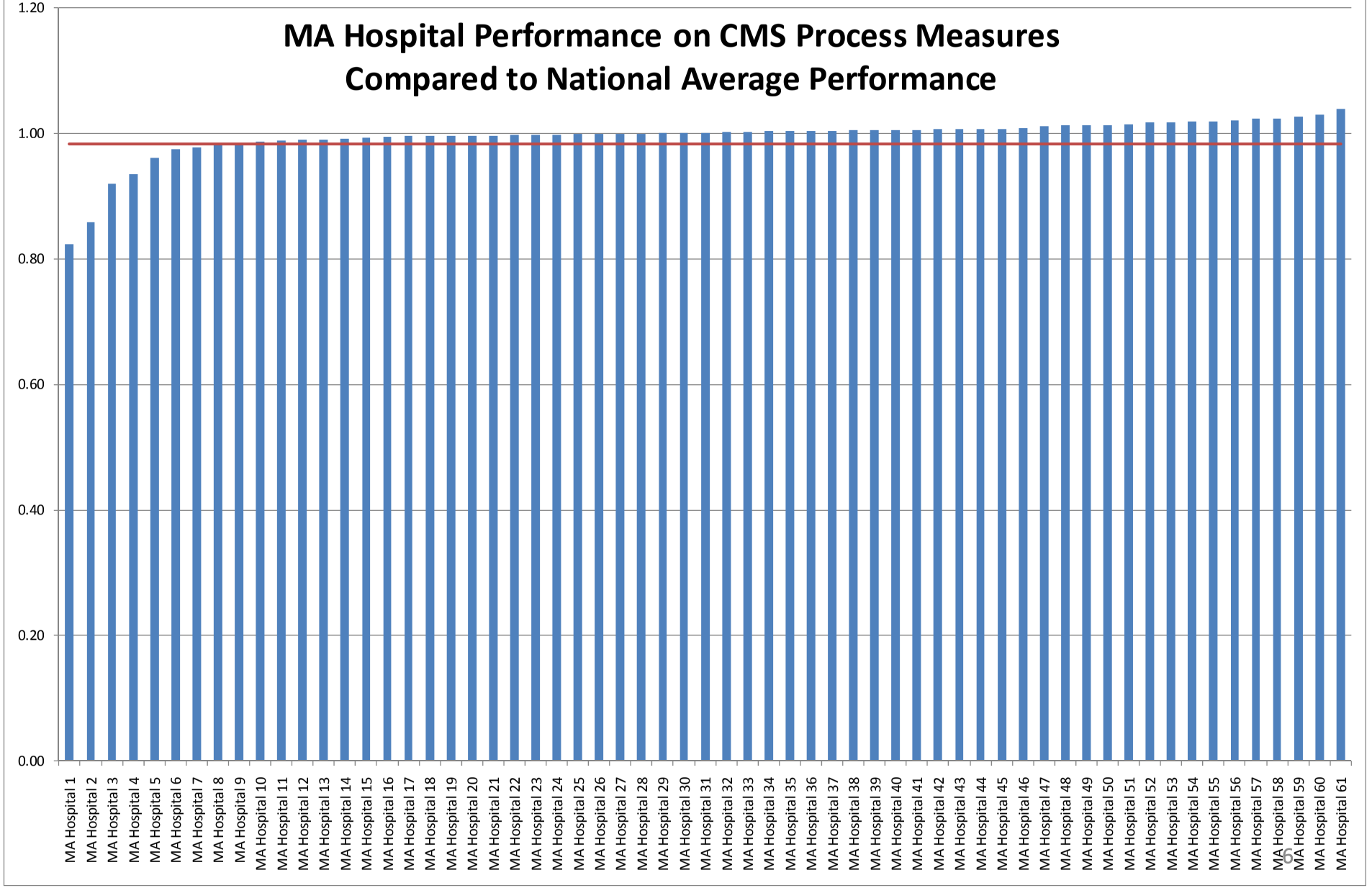
% Difference in Hospital Prices

	2008	2009
BCBS	180%	170%
HPHC	300%	350%
THP	240%	300%

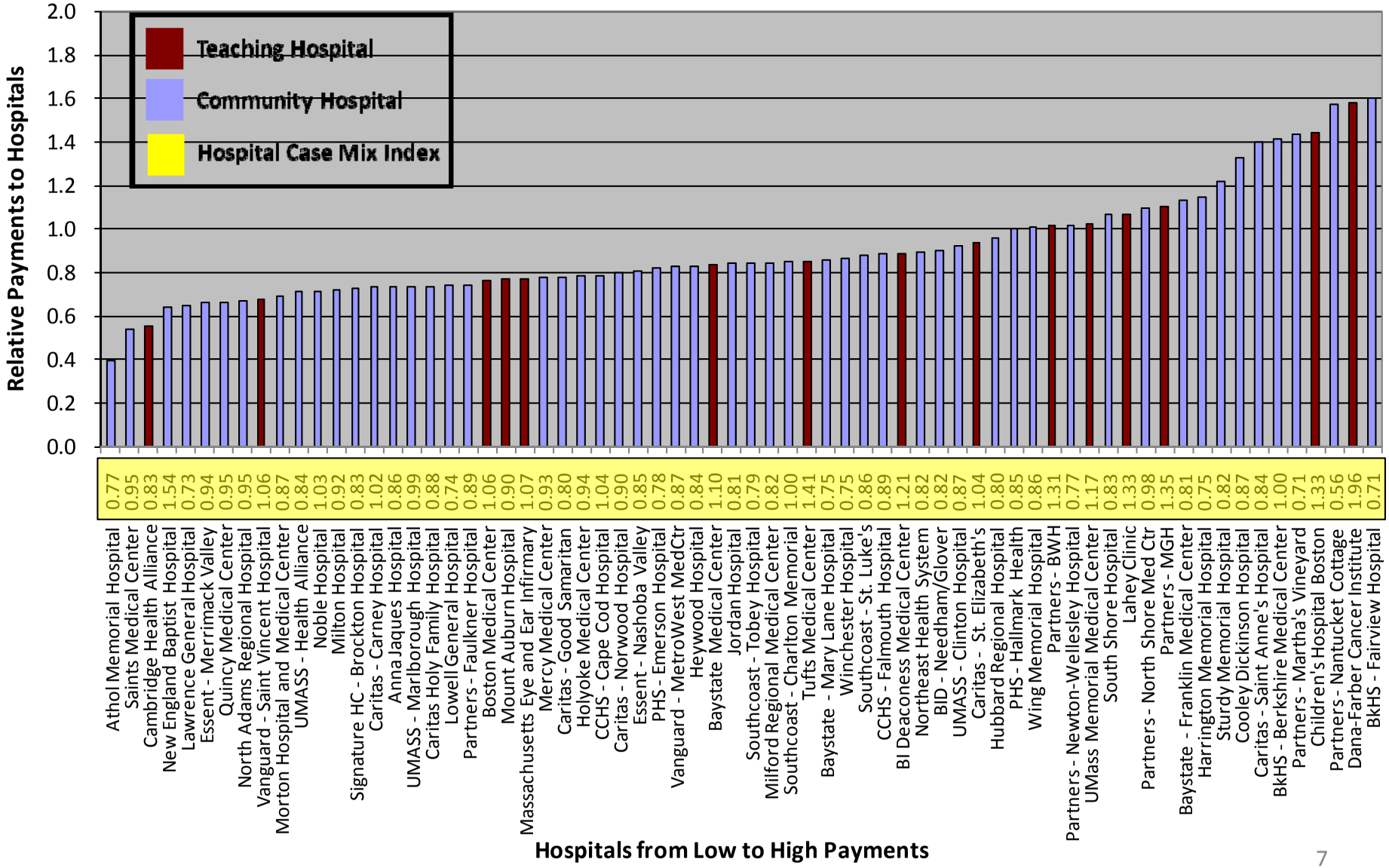
% Difference in Physician Prices

	2008	2009
BCBS	220%	240%
HPHC	130%	230%
THP	130%	150%

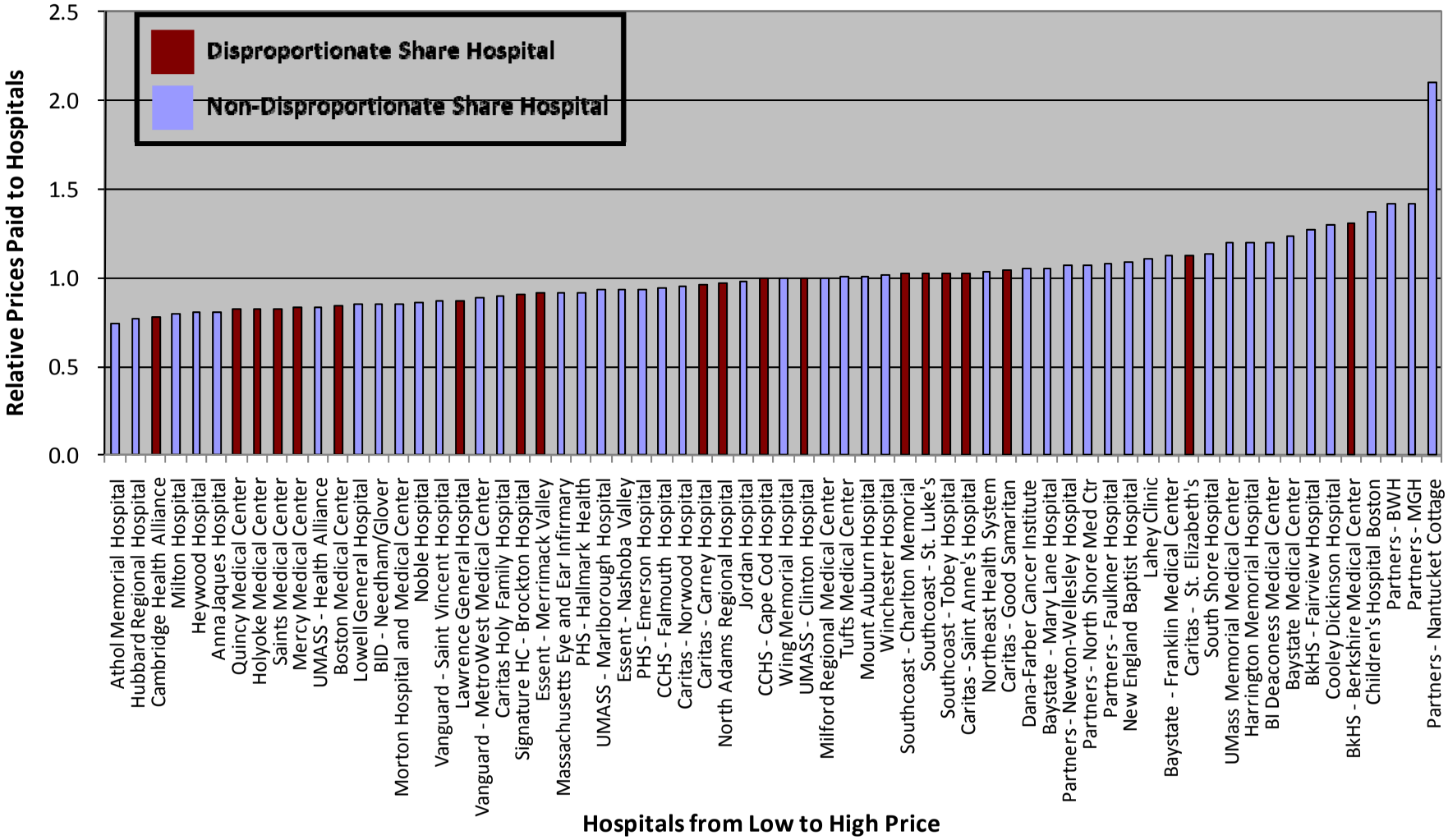
HIGHER PRICES ARE NOT ADEQUATELY EXPLAINED BY DIFFERENCES IN QUALITY PERFORMANCE



HIGHER PRICES ARE NOT ADEQUATELY EXPLAINED BY TEACHING STATUS OR COMPLEXITY OF SERVICES



HIGHER PRICES ARE NOT EXPLAINED BY PROPORTION OF GOVERNMENT PATIENTS

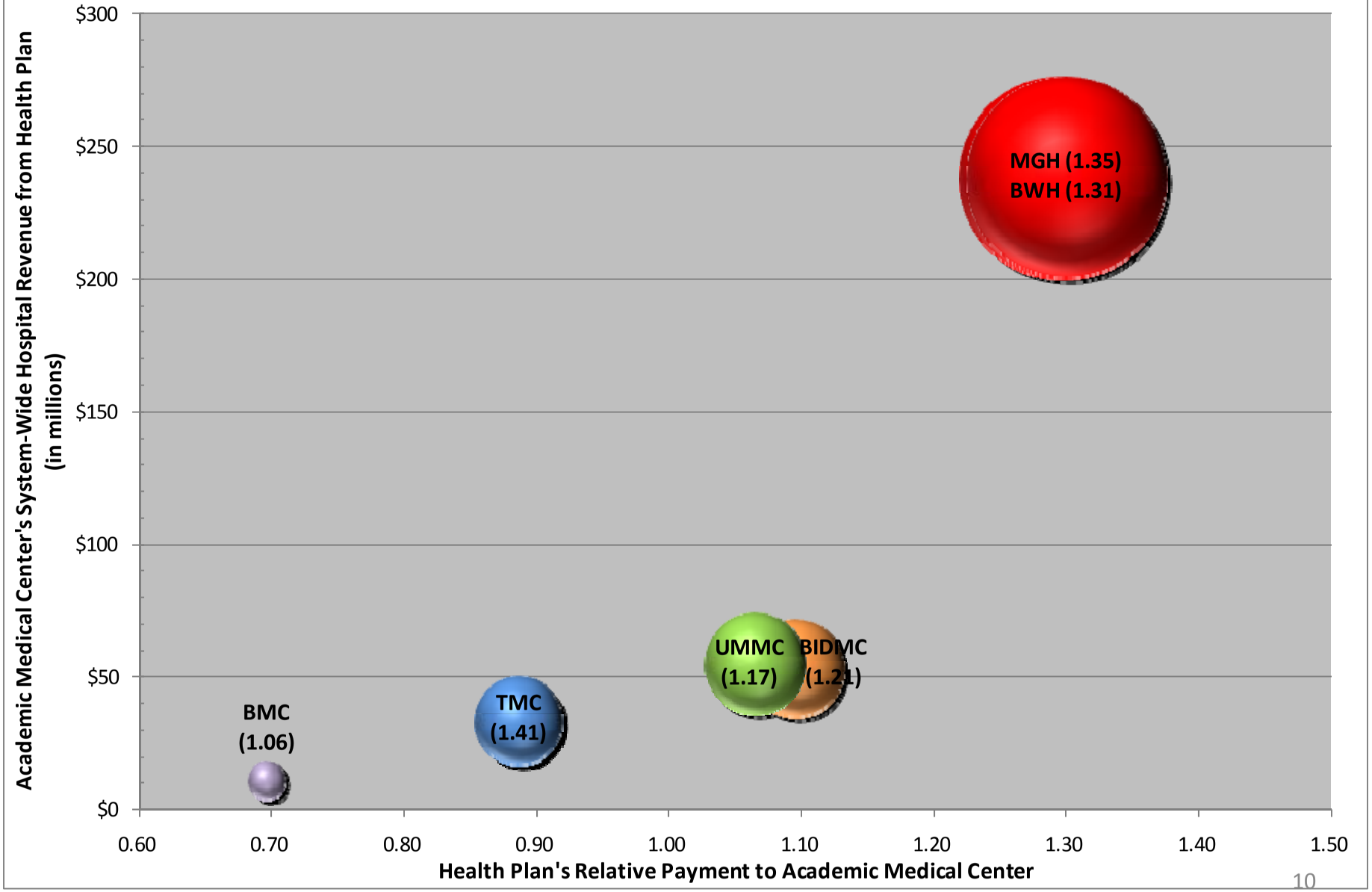


HIGHER PRICES ARE NOT ADEQUATELY EXPLAINED BY UNDERLYING COSTS: HIGHER-PAID PROVIDERS REPORT HIGHER COSTS TO DELIVER COMPARABLE SERVICES

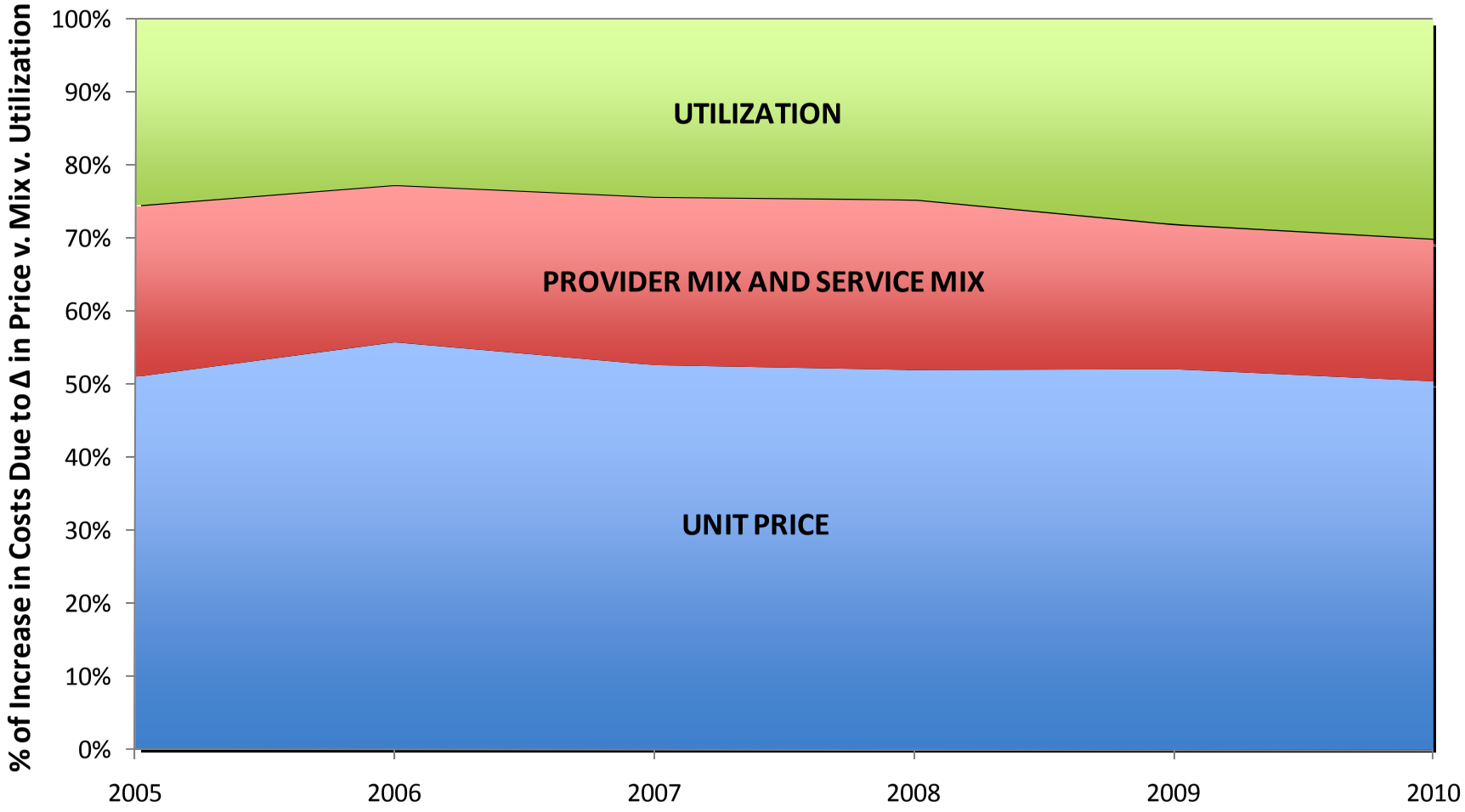
Hospital	Commercial Payer Margin	Government Payer Margin
Academic Medical Center 1	3.7%	-3%
Academic Medical Center 2	15%	-6.9%
Academic Medical Center 3	21.4%	-33%

"[U]nusually high hospital margins on private-payor patients can lead to more construction, higher hospital cost, and lower Medicare margins. The data suggest that when non-Medicare margins are high, hospitals face less pressure to constrain costs, costs rise, and Medicare margins tend to be low."
- MedPAC, Report to Congress, March 2009, page xiv.

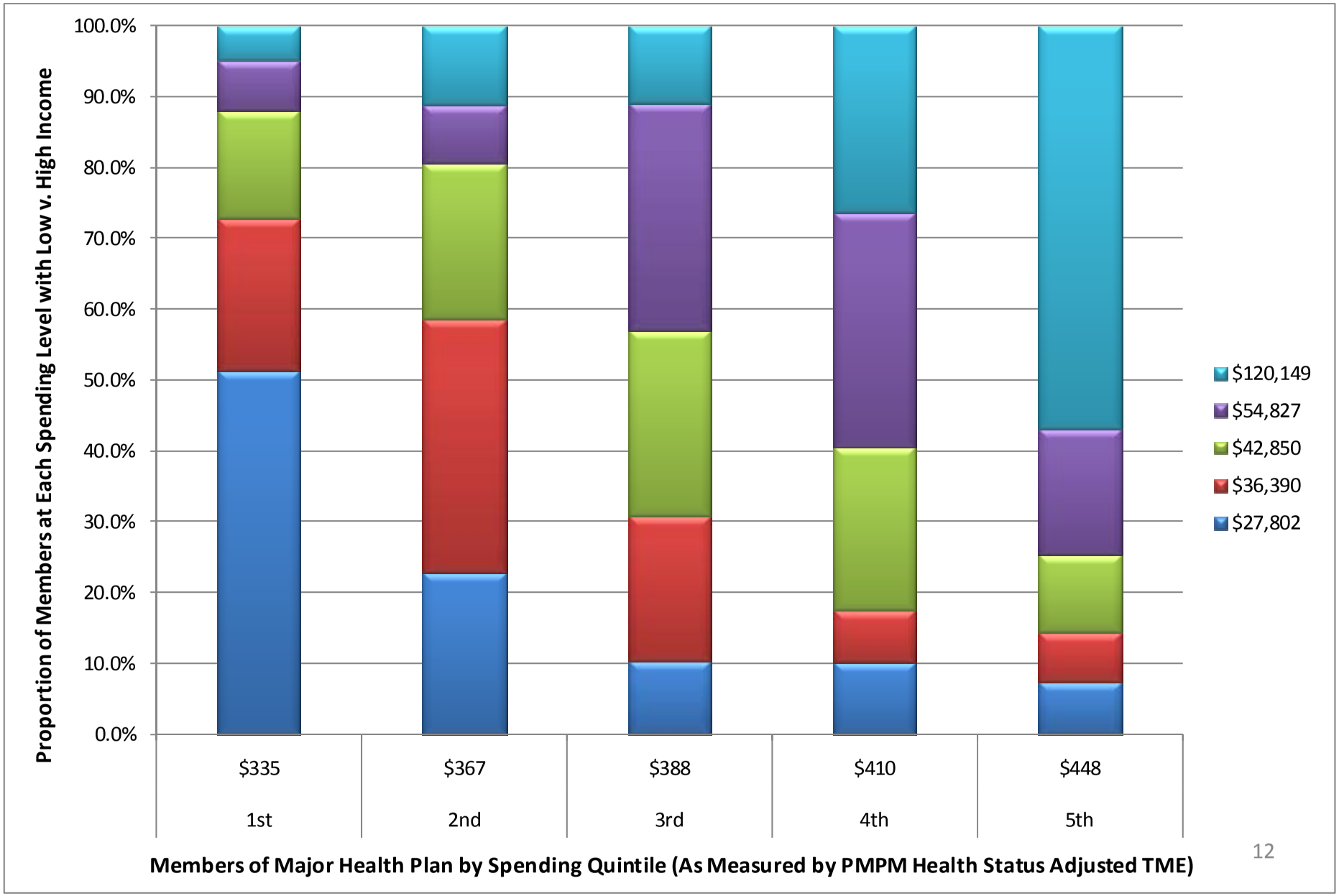
HIGHER PRICES ARE EXPLAINED BY MARKET LEVERAGE



PRICE INCREASES CAUSED THE MAJORITY OF THE INCREASES IN HEALTH CARE COSTS IN THE LAST SIX YEARS



TOTAL MEDICAL SPENDING IS HIGHER FOR THE CARE OF PATIENTS FROM HIGHER-INCOME COMMUNITIES



WIDE VARIATIONS IN PRICES PAID TO PROVIDERS COULD TAKE YEARS TO CORRECT

For illustration purposes only, examples of the number of years to rate convergence in one health plan's network assuming the lower paid provider receives a 3% a year increase greater than the higher paid provider.

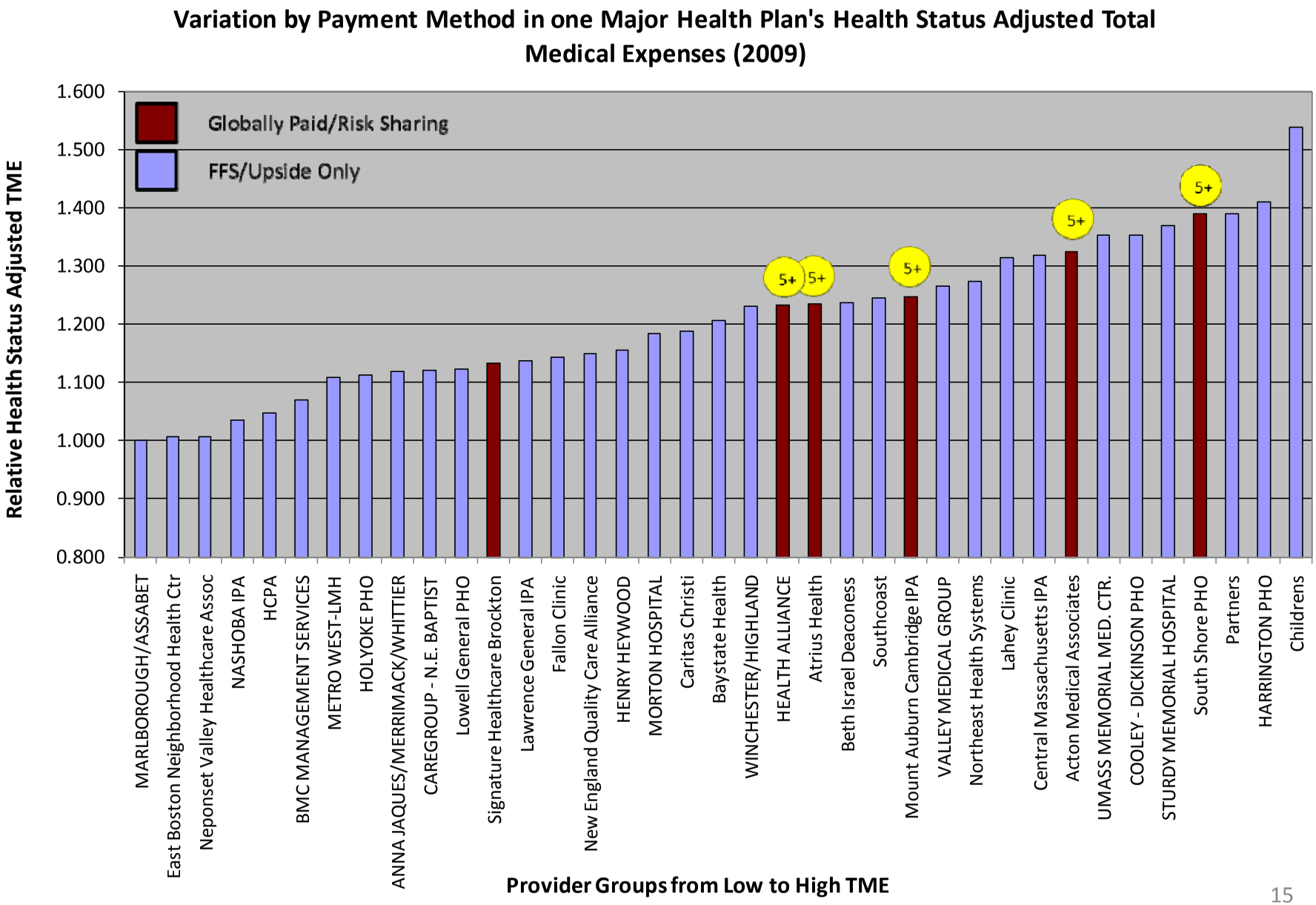
Hospital	Price Disparity		Years to Convergence	
	IP	OP	IP	OP
SS Hosp 1				
SS Hosp 2	31%	49%	10	14
Cambridge Hosp 1				
Cambridge Hosp 2	28%	40%	9	12
MetroWest Hosp 1				
MetroWest Hosp 2	15%	57%	5	16

Physician Group	Price Disparity	Years to Convergence
AMC Phys 1		
AMC Phys 2	16%	5
AMC Phys 3	19%	6
AMC Phys 4	44%	13
Cambridge Phys 1		
Cambridge Phys 2	84%	21

VARIATIONS IN PRICES PAID TO PROVIDERS EXIST IN GLOBAL RISK BUDGETS AS WELL AS IN FEE-FOR-SERVICE ARRANGEMENTS

- We found wide variations in the health status adjusted global payments made by health plans to at-risk providers.
- For example, in one health plan's network in 2009, one globally paid provider had a health status adjusted budget of approximately $428 per member, per month, while another had a health status adjusted budget of only $276 per member per month.

GLOBALLY PAID PROVIDERS DO NOT HAVE LOWER TOTAL MEDICAL EXPENSES



HEALTH CARE DIVISION PRESENTATION TO PROVIDER PRICE REFORM COMMISSION:

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OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
ONE ASHBURTON PLACE • BOSTON, MA 02108

July 13, 2011

C.4: Testimony of Panelists from 2011 Health Care Cost Trends Hearings- Price Variation in Massachusetts Health Services

Testimony of Normand E. Deschene, President and CEO of Lowell General Hospital

Good morning Acting Commissioner Carrington, Members of the Legislature, Attorney General's office, representatives and esteemed colleagues on this panel. It is my pleasure to come before you today to represent the interests of Lowell General Hospital; I must clarify that none of my comments today represent the views of the collective membership of the Massachusetts Hospital Association, of which I am the newly elected Chair of the Board of Trustees.

Thank you for inviting me to speak and to be part of the testimony for today's panel as we discuss payment variation among providers in Massachusetts.

As background, Lowell General Hospital is a 217 bed Community Hospital located in the City of Lowell, the fourth largest City in the Commonwealth. It is my 27th year managing Lowell General Hospital, 8 of which as President and Chief Executive Officer. I am proud to represent this important community hospital and offer it as an example of how balancing both cost and quality successfully offers an undeniable value proposition to the Merrimack Valley, local employers and to the insurance industry.

During my tenure at Lowell General, I have experienced first-hand the evolution of the healthcare payment system from cost-based reimbursement to HMO proliferation to P4P and now to Accountable Care. Lowell General has been highly agile at adapting to this ever-changing landscape. Our successful evolution is based upon unwavering core principles, which include compassion, service excellence, an unrelenting focus on quality and nursing, and clinical excellence; all with the underlying focus of remaining affordable to our Community.

The private payment system in Massachusetts is a free market system. Although the answer to the question of what causes wide variation in payment rate is complicated, we also believe the greatest determinant is very evident. It is leverage, as defined by market position, location and brand name that has been the largest drivers of the disparity in rates. I do want to point out, however, that the high focus on Academic Medical Centers being paid more than community hospitals is misplaced. The focus should be on what level or degree the premium should be driven by tertiary care and how to create parity for low cost-high quality community hospitals that are under paid. Academic medicine is one of the cornerstones of the Massachusetts healthcare system as well as one of the top three economic drivers. We appreciate and respect that fact. On any given day, from the City of Lowell, as many as 5 people are transferred from Lowell to one of the Boston teaching hospitals. We are thankful for the proximity of the country's best academic medical centers, we are grateful for their capacity to accept patients and for their expertise in caring for some of our very sickest patients. Nonetheless, the disparities in how much we are paid needs to be addressed.

Challenges to Containing Costs:

There are many factors that limit the ability for LGH to contain costs. One of the most problematic issues facing LGH and its affiliated physician hospital organization is the expansion of Provider Physician Networks. The LGH PHO's membership includes 80 PCP's and approximately 200 specialists. Several PHO specialty groups have recently chosen to affiliate with tertiary affiliated provider networks in exchange for higher fee schedules. This practice has been encouraged by tertiary-related provider organizations and is allowed by many of the private payers. To our knowledge these newly-formed relationships have demonstrated little or minimal clinical integration or efficiencies while primarily serving to drive up the cost of care and destabilize community-based provider networks. One of the unintended consequences of recent rate transparency is the highlighting of the vast disparities among physician fee schedules.

The LGH PHO works collaboratively to maintain its network of physicians, while balancing the needs of the PCP's, Specialists and the Hospital. Migration of any large physician group to other tertiary-related networks results in increased costs which undermines risk arrangements and causing animosity between local PCP's and Specialists. We believe it also opens the door to leakage to higher costs settings for care that could and should be provided locally. We encourage the health plans to look at this practice in light of the cost debate that is taking place.

Recommendations of the Special Commission on Provider Price Reform *App.C-143*

Strategies to contain costs –

Expansion of Services to Keep People Local

Lowell General has always been subject to extremely competitive market dynamics and as a result has been historically in the lowest quartile of reimbursement from private payers. Approximately 28% of our revenue is from Mass Health and Managed MCO payers and another 35% is from Medicare. LGH's lack of market leverage and its high governmental payer percentage have required that we be highly efficient in the delivery of high quality care. Lowell General is financially stable, with a growing market share and has invested significant capital into the Hospital over the last 7 years. Lowell General has expanded services to include tertiary level cancer services, neurosurgical services, cardiac and vascular services, a Level IIB Special Care Nursery and a Level III Trauma Center. By expanding the breath and scope of services provided, LGH has kept more patients and residents local, which reduces the costs for all, while improving LGH's ability to be a vital and efficient community Hospital.

AQC

Lowell General Hospital has united with its PHO and has signed a five year agreement with Blue Cross Blue Shield of Massachusetts commonly known as the Alternative Quality Contract. The five- year agreement spans from January 1, 2009, to December 31, 2013. The agreement is a full risk arrangement and includes a global payment, budget-based model. Lowell General Hospital has performed extraordinarily well in the first two years of this agreement by bending the cost curve and by dramatically improving quality scores. The cost trend reductions have been derived from several factors, including as referral management, utilization management, and managing high cost services. The referral management program includes reducing out migration from the service area. Referrals to other organizations are processed and reviewed by the Medical Directors of the PHO. Referrals are approved if the service needed is beyond the scope of services provided by LGH (most tertiary care level services), and/or if the patient had an existing relationship with a provider outside the LGH Network and is continuing treatment for that same condition. The referral management program takes advantage of the low cost structure of LGH by stemming the tide of outmigration. The DHCFP's conclusions contained in its report are true and accurate: every case that leaves LGH that can be take care of at LGH costs the system more.

In addition to referral management, the PHO has worked with the physicians to develop programs to review utilization of high cost areas such as inappropriate use of the Emergency Room, high cost imaging and other testing. Utilization management has been counter- balanced by the quality component of the Alternative Quality Contract. Blue Cross has designed a program to incentivize preventative care, management of chronic conditions and patient experience measures. The physicians and the Hospital work together in partnership on improving the quality measures year over year.

Concluding Comments

In conclusion, it is my belief, however, that we have to migrate toward a system of global payment with meaningful payments tied to quality performance, service excellence and patient outcomes. The current "fee for service system" rewards production rather than outcomes, and bakes in the pricing disparity and further builds the inequities between rich and poor which permeates today's system. Although there has been some criticism of the global payment model, I urge everyone to be patient. Systemic changes to the health care delivery system must be given an opportunity to take root and should not be changed through a regulatory response, which, to use a healthcare analogy, does little to address the causes but only responds to the symptoms. The necessary changes will take time, planning and require that the varied provider constituents work closely together. I encourage the Division and the Legislature to let the free market system design and develop the future.

Recommendations of the Special Commission on Provider Price Reform *App.C-144*

Testimony of Gary L. Gottlieb, M.D., M.B.A., President and CEO, Partners HealthCare System

Thank you for inviting me here today to speak about this important topic. My name is Dr. Gary Gottlieb, and I am the President and Chief Executive Officer of Partners HealthCare. Partners HealthCare is an integrated health system founded in 1994 by Brigham and Women's Hospital and Massachusetts General Hospital. In addition to its two academic medical centers, the Partners system includes community and specialty hospitals, community health centers, a physician network, home health and long-term care services, and other healthrelated entities. Partners is one of the nation's leading biomedical research organizations and a principal teaching affiliate of Harvard Medical School. Partners HealthCare is a non-profit organization, employing more than 60,600 individuals.

Our mission is to provide the best possible clinical care to our patients and their families, to search for cures that can improve that care, and to invest in the education of the next generation of leaders who will carry forward the lessons we have learned. All of this is in service to the communities that we touch every day, whether they are local or around the world.

In order to achieve this, we must attract the best and brightest to care for the sickest and neediest people among us. Ultimately, we want to be able to deliver and promote wellness – which is not how the health care system has traditionally worked. We need to move from a system that reacts to illness and its consequences to one that promotes overall health and wellness. This mission informs our science – the work that our researchers engage in every day to advance the science of medicine and translate that science into medical cures, another part of our effort to ease pain and suffering. And our mission guides our teaching programs, as we aim to attract the most magnificent young people who can carry this work forward to future generations.

And while we focus on our patients and families in our hospitals, we cannot lose sight of the needs of our communities. We work to ensure that the people in our neighborhoods are our partners, and to this end we have made significant capital and other investments to ensure that the quality of care in these communities is the same for all of us. We support community health centers to ensure the availability of high quality care in our communities. We provide financial support for programs that address domestic violence, youth substance abuse, homelessness, and racial and ethnic health disparities. And we provide economic opportunity, creating pathways for careers in health care for youth and community residents as well as for our incumbent workforce.

But it all starts with our patients. Our system offers a full range of services across the entire continuum of care – from primary care to the very highest levels of intensive care services, and everything in between – and the work that we do is extraordinary. Last year, more than one in six of our patients – over 14,400 – were transferred to Brigham and Women's and MGH from other hospitals in the hope that we could provide unique life-saving care. When the best care for the most complex cases is required, people turn to the MGH and the Brigham – and we are proud of that fact. But these are the very sickest patients – and there is a cost associated with providing this level of care and this level of hope to our patients and their families. Providing this care is essential to our mission, and we strongly believe that our hospitals' reputations for providing the best care in the most extraordinary circumstances speaks to the quality of the care that we provide in a way that no process measure ever could.

Indeed, Dr. Bo Pomahac, a plastic surgeon at the Brigham, has given four people their lives back with his extraordinary work in face transplantation. Dr. Dan Haber from the MGH recently developed a sophisticated, noninvasive test that can detect tiny traces of cancer cells in blood samples, potentially opening the door to revolutionary new ways of treating cancer. And our researchers have made vast strides in unlocking the secrets of Alzheimer's – developing groundbreaking genetic tests, understanding the fundamental biology of the disease, and identifying potential treatments. These researchers and practitioners are medical pioneers whose work at the frontiers of medicine make care better for all of us.

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This work also drives medical innovation, and we should not forget that health care is one of the state's principal engines of economic growth. Nearly one in six adults in Massachusetts – nearly half a million people – is employed in health care. Many more jobs are indirectly related to health care, whether it is a small business in the neighborhood of one of our hospitals or much needed construction jobs in what has been one of the worst economic times in memory.

As we consider the value of our hospitals, let me address the specific issue of prices. We do not negotiate prices for other hospitals, so I can't tell you how their prices are determined. I can just tell you about how we get to ours. Quite simply, we work backwards from our margin target of 2% for the entire Partners system to figure out what level of aggregate reimbursement from the payers will enable us to reach this target. In doing this, we must balance across a number of factors – across the network of providers that make up our system, across the range of services that we provide, and across the range of payers that we do business with, both public and private. This margin, which is set at a level to ensure stability and demonstrate fiduciary responsibility, is what enables us to achieve our mission. Higher reimbursements for services such as cardiology and orthopedics, which are highlighted in the state's report, are often used to subsidize poorly reimbursed services – one such example is mental and behavioral health. These reports do not examine the many service lines where Partners loses money. But we remain committed to mental health and substance abuse services when many other providers have closed beds because they were not financially sustainable.

We do not set prices on an individual service basis. A superficial analysis that merely compares the "price" one hospital receives for a specific service to the "price" of that service at another hospital simply does not capture a deep understanding of costs or reimbursement and is not representative of how prices are determined in the real world or how hospitals compare to one another. It is more relevant and instructive to consider the range of services provided by a particular hospital or hospital system and to understand how hospitals manage their finances, which, as I have noted, considers the full range of services provided by the hospital as well as payer mix and other factors, such as those also recognized by Medicare. The dialogue over price variations would be greatly enhanced by such an analysis and would better reflect how health care "prices" are determined.

I am particularly disappointed in the analysis included in the Division's report on health care expenditures because that report completely ignores the impact of public sector underpayment on private sector prices. That report showed minimal increases in spending on public sector programs because, quite simply, rates were cut. Price freezes or reductions do not improve efficiency or clinical management – they create a cost shift from one payer to another, and place upward pressure on commercial rates. Hospitals that cannot increase their commercial rates are forced to use their available resources to support ongoing operations, losing the ability to invest in their facilities and staff and remain financially stable. North Adams, which recently filed for bankruptcy, is an example of what happens to a provider with a 65% public payer mix when government doesn't cover the cost of care. We also believe that more attention should be paid to the issue of why small group premiums continue to experience significant volatility, given that providers are paid the same regardless of the size of a patient's employer. Indeed, we have been public that Partners' recent rate increases have averaged only 5-6% a year. The state should explore the difference between hospitals' rate increases and the rate of increase being imposed by insurers on small businesses.

As a society, we are exploring ways to pay for health care differently. But we should be careful that in doing so we do not lose critical services. We only need to look at what has happened to mental health services over the past 20 years for a cautionary tale, as the streets have become the de facto mental health system as providers have walked away from these under-reimbursed services. The payments that we receive for some Testimony of Panelists from 2011 Health Care Cost Trends Hearings services help to subsidize mental health, which is a critical part of our mission – we should not make the mental health situation worse than it already is.

As I mentioned in my testimony last year, the greatest opportunity for rapid cost reduction is also potentially the most humane, patient and family centered. Analysis of Medicare data shows that 10% of beneficiaries account for approximately 70% of costs. These individuals are severely ill, suffering multiple medical comorbidities, and many are near the end of their lives. A good number are also Medicaid eligible. Social, economic and behavioral challenges often complicate effective medical care and add significant costs.

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In the current health care system, care for this high-risk, high cost population is generally fragmented, addressing immediate and specific demands and circumstances rather than the whole of their personal and family needs. The absence of coordination results in care that is unplanned and reactive. Care is often inconsistent with best practices, patient centeredness and the most effective use of resources. Therefore, developing and implementing innovative approaches to managing and paying for the proper care for this vulnerable population is crucial. Even modest improvements will lead to a significant reduction in costs, reducing both commercial and public payments.

At Partners, we have tackled this issue through a Medicare demonstration project started at MGH — an example which holds great promise for patients in Boston and throughout the country. The program integrates nurse care coordinators into primary care practices to coordinate each patient's needs. Hospital readmissions dropped 20 percent, and emergency room visits dropped 13 percent for patients enrolled in the program. The return on investment is high; for every dollar spent, the program saved $2.65 in health care costs. CMS renewed the MGH program for another three years and we have expanded the effort to two more Partners hospitals, Brigham and Women's and North Shore Medical Center. Even beyond the financial impact, we should be doing this because it is the right thing to do.

We agree that we need to look carefully at the health care payment system to determine whether it provides the right incentives or pays for the right things. The circumstances that led to the development of the current payment system have changed, and we agree that we need to evaluate what we do, how we do it, and why, and figure out how to do it better. That is why Partners has identified as a priority a set of strategic initiatives through a system-wide effort to redesign the way care is provided while making it more affordable for our patients and their families, and this will include thinking differently about how we should be paid for this work. This work is engaging clinical leaders from across our system as they focus on improving our quality while making the delivery of care more efficient and effective.

The Division's report on price variation is only one step in assessing why hospitals are reimbursed differently from one another, and we welcome a more detailed examination of the issue as the Special Commission on Provider Price Reform begins its work. That being said, we should be careful not to overreact and overreach, especially on the basis of incomplete data and analysis – nor should we over-promise the effect of reducing variation, which is not correlated with overall price or cost trends. We should resist interventions that might cause disruption in the health care system lest we jeopardize precious resources – critical services being closed, physicians choosing to practice elsewhere, a diminishing of our ability to attract the best and brightest young people, decreasing community investments. We need to ensure that we make our system stronger, not weaker.

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Testimony of James Roosevelt, Jr., President and CEO, Tufts Associated Health Maintenance Organization, Inc.

On behalf of Tufts Health Plan, thank you for the opportunity to testify at today's hearing. Tufts Health Plan insures roughly 760,000 members. Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care for every member. Tufts Health Plan's Health Maintenance Organization (HMO) and Point of Service (POS) plans are ranked third by U.S. News & World Report / National Committee for Quality Assurance (NCQA) and its Medicare Advantage plan, Tufts Health Plan Medicare Preferred, is ranked number seven in the nation.

My testimony will address the current challenges and solutions for addressing variation in the prices paid for health services in Massachusetts. I make these comments in my capacity as CEO of Tufts Health Plan and not in my role as Board Chair of the Massachusett*s Associati*on of Health Plans (MAHP).

First, I would like to thank the Division of Health Care Finance and Policy (DHCFP) for releasing their 2011 Massachusetts Health Care Cost Trends reports. We agree with the following key findings of the *Price Variation in Health Care Services* report:

1. Prices paid for the same hospital inpatient services and for physician and professional services vary significantly.
2. Service volume tends to be concentrated in higher paid hospitals.
3. There is little measurable difference among Massachusetts hospitals based on the available quality metrics.

I also commend the work of the Attorney General's Office (AGO). We agree with the findings of the Attorney General's 2010 Report and 2011 Report. These three reports reach the same conclusion: tremendous price variation persists and it is not explained by differences in quality or complexity of services.

The AGO's Reports and DHCFP's *Price Variation in Health Care Services* Report attribute these price variations to the size, geographic location, brand power and/or unique specialty of certain providers. We continue to be concerned about the level of consolidation that already exists and continues to grow in our market place and how it may further exacerbate the market power and price variation problem.

Solutions

While some price variation is warranted, variation should not be excessive and should be linked to quality and complexity of services. The AGO's report raises a very important point regarding the ability of the market to contain costs based on the current dysfunction which has led to distortions in price. The AGO's 2011 Report suggests that immediate and temporary statutory intervention may be required, in the short term, to rectify unwarranted and excessive variation. We believe this recommendation deserves serious consideration.

It is our opinion that unsupported price variation must be addressed to truly reign in costs, but that any government intervention should not be heavy handed and that it should facilitate or complement a transition to longer term, market based solutions. Once addressed, the greatest challenge we confront is in the design of care coordination models which engage providers and patients to concurrently reduce the cost of health care and improve quality.

Much has been written about the potential of new risk-based, global-based contracting models to solve this problem. In fact, the AGO's 2011 report states that a "shift of payment methodology by itself is not a panacea for controlling costs…and that a shift …without fundamental changes may not only fail to control cost, but may exacerbate market dysfunction and market inequities…" We do not disagree with this finding. In fact, we view risk or global based arrangements as one piece of a complicated puzzle. These arrangements need to be paired with two elements to support its implementation: 1) product designs that create the right incentives for members and providers as they seek and direct care; and 2) clinical management programs that support providers who increasingly share employers' goals of reducing health care cost trends

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At Tufts Health Plan, we have introduced a “Coordinated Care Model” which integrates all three components.

The first component of our model is Provider Reimbursement. We are increasingly focused not just on how much we pay, but on the incentives these payments create for care delivery. We have developed a risk-based, global budget contract model that pays providers for on their ability to manage the overall cost and quality of care. Since 2009, Tufts Health Plan has successfully increased the number of Commercial HMO members in a global budget model from 18% to 41%. Our Medicare Advantage product has roughly 95% of its members in a similarly styled product which has been in place for over 15 years. There is no longer a “typical” riskbased provider in our network. They include Boston-based tertiary providers along with community organizations. Perhaps the most important element that we must all consider in these arrangements is whether the budget or risk-based arrangement is *affordable* (and I stress affordable) and not simply a perpetuation or institutionalization of the present price disparities.

The second component is Product Design. It is the health plan’s job to develop products that provide the member with the right incentives to engage their PCPs. For example, if a member needs a consult from a specialist, they should have an incentive to engage with their PCP and explore whether the community cardiologist can provide the same (or higher) level of care without the cost of going downtown. We believe our limited and tiered network products provide these incentives. The price differential for our limited and tiered network products ranges from between 14% and 16% when compared to our traditional, broader network products. We believe this premium differential combined with copayment options provides the right incentives for members and providers as they seek and direct care. But it is not simply about product design. We must design products that support the administration of risk-based or globally based arrangements. And, if in the process, they also provide lower cost providers with increased referral volume, we will have achieved a dual objective.

The third key component is Care Management. Our approach to care management comprises three strategies: direct management of utilization to reduce waste; management of conditions and diseases; and a focus on health and wellness. A major function of a health plan is to routinely monitor for under use and overuse of services and work extensively with providers to monitor the quality of care being delivered. We have also created a variety of clinical programs designed to reduce unwarranted utilization and variation in the delivery of care. One of our care management programs has earned a return on investment of $1.00 spent to $4.80 saved. We have also created tools to support member and provider engagement in health and wellness initiatives.

In a fee-for-service world, we have helped members manage the type of services they receive (sometimes identifying points of under-care; other times helping with transitions to other lower-intensity places of service). In a world of aligned incentives, we have a different opportunity and that is to develop programs which complement or support those programs the provider may already offer. We all agree that the physician or nurse is in the best position to coordinate the care of their patients when they are equipped with the right tools and provided the right incentives.

We believe these three variables - - Provider Reimbursement, Product Design and Care Management - - should be brought together as they are in our Coordinated Care Model. We view risk as a key enabling factor, but believe it must be complemented by other areas of organization to be successful.

Conclusion

In conclusion, as the recent reports show, price variation is a problem that needs to be addressed as we attempt to control medical costs. While a temporary statutory intervention may be required in the short-term, we believe market based solutions such as our “Coordinated Care Model” hold great promise for long term improvements in both quality and efficiency. We look forward to working with state agencies, legislators, employers and providers on ways to address the Commonwealth’s unsustainable health care cost trends.

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Testimony of Andrei Soran, CEO MetroWest Medical Center

Good Morning. My name is Andrei Soran. I am the President and CEO of MetroWest Medical Center. MetroWest Medical Center is a full-service, investor-owned, community teaching hospital system dedicated to meeting the health care needs of the MetroWest region of Massachusetts by providing high quality, affordable, health care close to home. We are a 269-bed health care system — the largest between Worcester and Boston — and our system includes Framingham Union Hospital, Leonard Morse Hospital in Natick, MetroWest HomeCare and Hospice, and the MetroWest Wellness Center, which is an outpatient diagnostic imaging and rehabilitation center.

MetroWest Medical Center plays a critical role in the MetroWest community. Beyond providing medical care for thousands of patients – many without adequate insurance coverage, MetroWest is a major employer of local residents and supports various community organizations that share the mission of caring for those in need. MetroWest employs 2,450 local residents with an annual payroll of $136 million. We paid more than $1.7 million in real estate and personal property taxes to the Towns of Framingham and Natick last year and $1.2 million in sales tax to the Commonwealth of Massachusetts, while providing $ 3.5 million in free care to the residents of the communities we serve. MetroWest is owned by Vanguard Health Systems which also owns Saint Vincent Hospital in Worcester and 25 other hospitals in Chicago, Detroit, San Antonio and Phoenix, Medicaid health plans in Phoenix and Chicago and free-standing surgery centers in California.

Thank you for inviting me to offer testimony today on the subject of health care costs.

I applaud the ground breaking work done by the Division of Health Care Policy and Finance in the recent reports on price variations in health care services, and premium levels and trends, as well as two reports of the Office of the Attorney General, the most recent just released on June 22, 2011. These reports describe the challenges that my hospital and others like it across the Commonwealth face as we attempt to fulfill our mission. Like many community hospitals, MetroWest is faced with significant financial pressures. At the center of these financial challenges is the reality that we and our peer institutions are inadequately reimbursed for the high quality care we provide. There are wide variations in the rates of reimbursement to hospitals for the same services and these variances are a driver of unsustainable health care cost increases.

The more highly paid hospitals and medical groups are using this advantage to grow at the expense of lower priced providers who are losing volume. Higher rates of reimbursement allow the more fortunate providers to pay better salaries, and to attract and retain staff and doctors. They allow for better, newer equipment and facilities, creating marketing advantages. They also fuel expansion plans, further encroaching in new territories at the expense of lower paid providers.

MWMC is reimbursed on average 25-40% less than other hospitals in its service area for the same services with little or no difference in quality. As a result, the burden of operational improvements further erodes any margin, limiting the ability to invest in facilities, new programs and staff and threatening MetroWest's ability to continue to provide a comprehensive range of services in the MetroWest region for the long term. Without access to our hospital, patients would be forced to travel greater distances to obtain care at significantly more expensive hospitals, raising everyone's overall insurance costs. For businesses, towns and cities, labor unions and increasingly consumers, who are paying the bills, this will mean unnecessary higher costs and out-of-pocket expenses.

MetroWest's paramount focus is to ensure the safety of its patients and to provide the highest quality care possible to those who live and work in the MetroWest region. I believe that we do an excellent job in this regard as described in general terms in the aforementioned reports and evidenced more specifically by any number of public report cards including U.S. Department of Health & Human Services' ***Hospital Compare*** and the Massachusetts Health Care Quality and Cost Council's ***My Health Care Options***. For example, MetroWest Medical Center significantly improved its safety record, quality of care and patient satisfaction over the last 3 years, and I am providing a document that illustrates that. Payments however have been stagnant. This is despite the fact that the quality outcomes at our hospitals meet and often exceed those at other hospitals in our primary service area. The OAG and DHCFP reports document this and describe the underlying reasons.

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Disparities in payment to physicians have also created systemic stress at local levels. It makes no sense for primary care providers to experience disparities in payment up to 30-40%, while living and working in the same community, serving the same kind of patients and providing the same kind of care. In addition, the affiliation of those providers with higher reimbursed institutions creates a flow towards the higher cost hospitals, further weakening local units of care.

With your indulgence, I would suggest some solutions:

- Allow integrated systems and providers to directly access employers and offer attractive prices in exchange for higher utilization of their resources. I will share an example of what we are doing to be proactive in that area in a moment.
- Ensure that large systems such as Partners, Atrius, and BI allow medical information exchange with other providers. The exclusivity of data control prohibits efficient care at local level. Regardless of the design of the limited care networks promoted by insurers, without the information, care will not transfer to lower cost providers.
- Create interim steps on the way to ACOs. The difficulties in managing risk can be mitigated by allowing development and payments for Bundling of high cost conditions, and Medical Home models.
- Understand that for providers to be assigned higher levels of risk, infrastructure is needed. The role of insurers would change and/or diminish and the funds should be transferred to providers.
- The cost containment measures contemplated by the different regulatory and payer organizations and bodies should not only seek to reduce payments to the “haves.” They should also seek to balance their payments so that effective and efficient providers can maintain and grow their operations. Some of the recommendations in the Attorney General’s latest report support some of these solutions.

As I mentioned before MetroWest Medical Center, and Saint Vincent Hospital in Worcester are working hard to ensure the viability of our hospitals in the current environment in a proactive way. Being high quality and lower in cost can be advantageous when the people paying the bills know it, and when insurance plans are available that incentivize the use of those providers who offer “real value.” That “real value” is high quality care and high patient satisfaction at a relatively lower cost. MetroWest Medical Center and Saint Vincent Hospital have been designated as “enhanced” or “Level 1” hospitals by all of the principal health insurers in the Commonwealth. Subscribers or persons insured by these new insurance products enjoy lower out-of-pocket expenses when they obtain care at hospitals like MetroWest, and we are advertising that Preliminary results are encouraging. The Group Insurance Commission recently announced that 30% of the 58,000 active state and municipal employees they cover have enrolled in what they describe as “limited network” plans which favor the use of hospitals like MetroWest. Several private employers have adopted “tiered” plans that also favor the use of “enhanced tier” hospital like MetroWest. For example, Polar Beverages has experienced a 250% increase in utilization while decreasing their costs at our “enhanced tier” facilities as opposed to the alternative “basic tier” hospital. This alteration in cost per member will create an opportunity for Polar Beverages to negotiate lower premiums at its next renewal.

These encouraging outcomes are a direct result of the pioneering work done by the Attorney General and the policies of the Patrick-Murray administration. I urge you to continue down the path of transparency, making the public aware of both the quality of care provided by Massachusetts hospitals as well as the actual cost of that care as measured by rates of reimbursement insurers pay hospitals and physicians.

Recommendations of the Special Commission on Provider Price Reform *App.C-151*

Testimony of Ellen Zane, President and CEO, Tufts Medical Center and Floating Hospital for Children

Good morning, and thank you for this opportunity to testify with some of my august colleagues today. We are all here because health care costs continue to rise in Massachusetts, placing a burden on its citizens, its businesses and its economy. This is an extremely serious issue and one that deserves our best efforts to solve – even when those efforts are difficult and challenge the status quo. I would first like to commend you, Acting Commissioner Carrington along with Governor Patrick, his administration officials, the Attorney General and the Legislature for recognizing this critical issue and for continuing to ensure it remains a priority.

I would specifically like to commend you and the Attorney General for continuing to investigate and report on aspects of the health care system that have been in dire need of transparency. These reports astutely point out the areas needing greater scrutiny and change in our course of action. I am glad you have convened us all here again because more must be done to mitigate health care costs increases to consumers and disparities among providers – two problems that are intertwined.

I wish it were not true, but a great deal of what I have to say today is similar to what I said more than a year ago at the first hearings held on health care costs trends in Massachusetts. My comments are remarkably similar because a year later the market is remarkably the same. I believe it is wishful thinking to say that the market is working. The recent set of reports from the AG and DHCFP clearly demonstrate that price is still a major cost driver in the market, that huge disparities still exist, and that there isn't one silver bullet that will resolve the inequities or reduce health care costs. The DHCFP reports showed that many patients continue to get treatment for the most common conditions at the most expensive providers. The AG's report showed that huge pricing disparities still exist, even among providers who are globally paid, and these disparities bear no relation to quality. Searching for quality metrics that justify higher rates will never justify the degree of disparities.

I firmly believe that as long as these disparities exist and consumers do not have clear incentives to seek out high-quality, lower cost providers, we will not be able to bend the cost trend. Clearly there is much more work to do to fix what is broken in this market, and proposed solutions such as global payments are not the cure-all. It will take multiple creative solutions that will require the participation of all members of this market: consumers, employers, health plans, government and providers.

Solutions must include correcting the wide and baseless payment disparities among health care providers that disappointingly still exist today – despite being revealed several years ago. In addition, employers and all consumers – the wealthy and those struggling financially – must have incentives for selecting high-quality, value-priced hospitals and physicians like Tufts Medical Center and New England Quality Care Alliance. Furthermore, providers who treat significant populations of Medicaid payments must not face discriminatory pricing from insurance companies (as was shown in a recent DHCFP report) – or they must be compensated in some way, either by the government or private payers, for the enormous financial burden of caring for this population. We are not looking for a "race to the top" but we can never support any approach that bakes in the disparities and further punishes those who serve higher levels of Medicaid patients.

While we would all like to believe that the market can resolve these issues, the data clearly shows it has not. The longer I participate in and observe this market, the more I realize that we have been confusing some tweaks to the system with true reform, and it is clear, as the latest DCHFP and AG's reports demonstrate, that is not enough. The market has not and will not drive itself to a healthy equilibrium all on its own: there is a need for some market guidance. This must be done carefully, because, as the Governor rightly points out, this is very complex and the ramifications are consequential. I agree with the recommendation in the Attorney General's report: there is a need for a stronger hand to balance the market and create a system that will reward efficient delivery of high quality care. We must be very cautious of some of the approaches already put forth, and ensure that they do not bake in the disparities or ignore the role that underpayments by government has on premiums. These approaches cannot include across the board, one-size-fits all fixes that exacerbate the problems for "have not" providers. Such a result would be wrong minded.

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At Tufts Medical Center, we believe we must create changes in the system that not only curb health care spending, but also build a more integrated, accountable and high-quality care delivery system. Before sharing my thoughts and concerns about the pricing disparities in our market, I think it is important to share some background about Tufts Medical Center and our integrated physician network, New England Quality Care Alliance.

- Though it is not widely recognized, Tufts Medical Center cares for the most complex population of patients of any full service medical center in Massachusetts. We provide a continuum of care involving patients who range from the tiniest fragile premature infants to adults who need brain surgery and lifesaving heart transplants. And although we are a much smaller hospital than many of our peers in Boston, the variety of services we provide to these most complex patients is comparable to our fellow academic medical centers.
- Despite the unusually complex population that we care for, the quality of the care we deliver is among the best in the city. Specifically, our mortality and complication rates are the same or better than many of our bestknown and well respected competitors in Boston and elsewhere. By virtually every measure of patient care and outcomes, we are as good as or better than our fellow AMCs. In 2010, Tufts Medical Center ranked 6th in the University Health System Consortium's quality rankings of 98 percent of the academic medical centers in the nation. This ranking looks at a broad range of objective and nationally accepted quality measures. None of our local competitors ranked in the top 10 on this list, despite the fact that Tufts MC is paid less than almost all of them, and paid less than many local community hospitals.
- Approximately 25 percent of Tufts Medical Center's patient population is insured through Medicaid, making us the second largest Medicaid provider of any full service teaching hospital in Boston. Only Boston Medical Center has a larger share of Medicaid patients. In fact, Tufts Medical Center has more than double and triple the amount of Medicaid share as compared to the other full-–service Boston teaching hospitals. We are a so called "safety net hospital" for a large and vulnerable population. Inspite of – or perhaps because of - this fact, we are the second worst-paid hospital in our peer group by private insurers. In fact, data from a major insurer shows that we are actually paid less than many suburban hospitals and physicians that care for far less complex patients and serve only a very small fraction of the Medicaid population.
- We are not paid slightly less than our highly respected competitors, we are paid significantly less– 30% to 70% less than our competitors. And the amazing physicians who care for our patients are paid 25–75% less than their colleagues across town and around the state.

To answer the calls for action *and* sustain the health care sector that is critical to the health of our citizens and our economy, we must address the fundamental issues of price disparities, incentive alignment and government underpayment.

1. Price convergence is imperative for a healthy and sustainable market.

Last year the Attorney General brought to light the staggering payment differentials in the health care market and the leverage wielded by the best-known or geographically-isolated providers. A market of "haves" and "have nots" has clearly emerged. A provider's quality, mission, case mix or share of publicly-insured patients does not appear to drive the prices set by insurers. It remains incredibly difficult for highly efficient and effective providers, like Tufts Medical Center and its NEQCA network, to compete with the market's Goliaths when pricing disparities are as significant as they have ever been. The most highly-paid providers continue to hold massive, unfair advantages when it comes to physician recruitment, technology acquisition, marketing dollars, brand-recognition and overall consumer awareness. With no incentives to direct them toward high-quality, lower-cost providers, consumers continue to flock to the most expensive providers. Costs to all consumers – including those who do use lower-cost providers – continue to rise.

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As the Attorney General points out in her latest report, global payments alone are not addressing the rate disparities. Neither will they automatically deliver higher quality and lower costs. Global payments – when done correctly – may incentivize providers to better coordinate care, but just like fee-for-service payments, they are the result of a negotiation between provider and insurer. From what we can tell from the Attorney General's report, providers who have significant market leverage have been able to use it to secure high global payments just as they always have to secure high fee-for-service payments. If global payments build in the current market disparities by setting global budgets purely on historical levels, they will do NOTHING to lower health care costs in this or any other market.

I believe there are several factors that must be considered when addressing the bad outcomes of these disparities.

- Not all systems are equally efficient - new payment systems should not reward organizations with higher total medical expenses, and they should not punish already low-cost providers.
- Providers must be categorized and analyzed for efficiency, quality and payment by peer group for true "apples to apples" comparisons among institutions. Only then can we determine appropriate payment rates, which should be at least at the average of other hospitals in their markets and peer groups.
- For global payments to bend the long-term trend in health care spending and to provide a viable surplus to all providers, some redistribution will be required

Once the payment gap is addressed, global payment contracts could be effective in aligning incentives to achieve high quality and efficient health care. While a number of insurance products incentivize providers to reach quality goals with additional payments for achieving benchmarks, so far these incentive payments have not significantly changed the relative rates paid to providers, and hence they have yet to do anything to change the inequities among providers in this market. We do think that providers should be rewarded for high quality and incentivized to provide high-quality care, but underlying price differentials must still be addressed.

To be most effective in correlating prices with quality, improvements in quality measurement systems need to occur. For example, critical to ambulatory care is moving from quality metrics based on claims to metrics based on actual clinical information from electronic medical records. Several factors that should be recognized in differentiated prices are:

- Quality – providers should be rewarded for meeting quality standards
- Efficient care management – providers who demonstrate efficiency in treating patients should not be penalized by well-below market rates
- Safety net services offered and Medicaid mix
- Acuity – the severity of illness treated by the provider
- Teaching status – Academic medical centers bear a significant burden in training the next generation of physicians and other caregivers, and they also are required to maintain and provide a higher level of critical services essential to all communities.

I have gained many years of experience learning to integrate doctors and hospitals and the services they provide patients. And I can tell you, it's not easy, and it certainly doesn't happen overnight. There is a great deal that goes into meeting the goals of better quality, true integration and savings in the long run. Tufts Medical Center, along with our community physician network, was the first, academic medical center to enter into the Blue Cross Blue Shield Alternative Quality Contract (BCBS AQC). The BCBS AQC is a global payment model with significant quality incentives embedded within it. Our participation in the AQC has provided us with valuable experiences and insights to the success and pitfalls of global payments.

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As I've said, global payments, in and of themselves, will not address the underlying problems in the market. The report shows that a low-paid, fee-for-service provider, practicing at a low-cost hospital will be less expensive than a high-cost, globally-paid provider. If we bake in the current market inequities, we will have accomplished nothing. In a global payment model, a low cost system can't be expected to achieve trend reductions in the same way as the high cost system. Further, we need to be cognizant of the up-front costs and investments necessary to develop successful systems – because they are significant.

2. Simultaneous pursuit of alignment of consumer and provider incentives is essential.

Consumers should have better access to data that reflects the cost and quality of the providers they choose. However, as stated in the Attorney General's report, it is unlikely that consumers will respond to this information unless they are prompted to do so by insurance plan designs that encourage them to seek out low-cost, high-quality providers. I agree whole-heartedly with the Attorney General that limited and tiered networks are the best ways to achieve this incentive alignment. Consumers who responsibly choose lowercost, high-quality providers should be financially rewarded with lower copays and premiums. Insurers must also provide real-time information about benefit design to providers, so that individuals and their caregivers can be fully-informed about the choices patients are being asked to make.

3. Government underpayment must be addressed.

I would be remiss if I did not also mention that one of the drivers of premium increases is cost shifting from government to private payers and cost shifting from government directly to providers through fee cuts. The ever diminishing level of government reimbursement in the face of increasing government mandates forces providers to try to charge more to the private sector, or to simply endure the reduced reimbursement from state contracted rates. Often it is the latter because providers with the highest Medicaid populations are also among the most poorly paid by commercial insurers, as the DHCFP report shows. As I noted, more than a quarter of Tufts Medical Center patients are on Medicaid, and we continue to receive much lower commercial rates than our peers for no reason whatsoever. We do believe that because institutions like Tufts MC have so many Medicaid patients, commercial payers actually feel less pressure to provide reasonable rates. Insurers should not be allowed to discriminate against providers who serve a high percentage of poor patients. I believe one reasonable remedy for this would be to require insurers to prove that they are not discriminating against hospitals and physicians with a high Medicaid mix and are paying them a market-competitive rate.

You've all heard me say that there is no silver bullet and it must be an all-hands-on-deck approach; providers and insurers, government, employers and consumers must all put some skin in the game to move forward on these issues. That is still true and will remain true as we work to address these thorny issues in our market. I am heartened by the attention that the Administration and Legislature continue to devote to these issues. Our patients, our medical institutions and our economy deserve nothing less.

Thank you again for the opportunity to testify today and I will be happy to answer any questions.

Recommendations of the Special Commission on Provider Price Reform *App.C-155*

2011 Health Care Cost Trends Hearings: Pre-Filed Testimony from Certain Payers and Providers Related to Price Variation

Questions for Payers

What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in the order of impact on negotiated rates.[1]	**BMC HealthNet**: 1. Comparison to appropriate benchmark… 2. Network Adequacy and Provider Commitment… 3. Provider Leverage… 4. Comparison against similar providers within geographic regions… 5. Current and projected utilization of services… 6. Acceptance of Managed Care…
	CeltiCare Health Plan: CeltiCare's network strategy from inception has been focused on negotiating contracts with high quality, cost effective providers. In addition to these 2 factors, adequate geographic coverage is another import consideration during the contract negotiation with all provider types. CeltiCare would rank these 3 factors all as equally important.
	Fallon Community Health Plan: Containing cost is FCHP's most important priority in rate negotiations. Each year we develop a budget of targeted rate increases for each major provider. These budgets are used to develop our annual expected total provider budget or costs. Our contracting goal is to stay at or below the budgeted provider increases. In developing our provider budgets and then preparing for provider negotiations, we consider a variety of factors, and we consider and analyze a variety of available financial information and utilization data pertaining to the particular type of provider with whom we will be negotiating. The public information includes, for example, the Division of Health Care Finance and Policy annual hospital cost reports, Medicare cost reports, and Medicare and Medicaid fee schedules. For providers who are already participating in our networks, we analyze their actual historical claims data for our members who use these providers, to measure utilization and costs. This analysis focuses on, among other factors, the providers' (i) rates of admissions and inpatient days, (ii) average length of stay, (iii) ambulatory surgery, laboratory, and radiology utilization, and (iv) pharmacy costs. For providers new to our network, FCHP's analysis is based on a selection of claims data from participating providers analogous to that particular provider's type, size, makeup, and pertinent regional characteristics. For physicians we also consider (i) utilization estimates based on the DXCG methodology (a severity tool adjustment that

[1] Testimony submitted by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and United Healthcare of New England was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

	normalizes different medical groups) and the Group Insurance Commission methodology for evaluating physician quality and efficiency, and (ii) their administrative and management fees. We also assess the provider's willingness and ability to accept a risk-based reimbursement structure. By analyzing this information, we can better determine how efficient the hospital or physician group is as compared to others in managing their costs, and in managing the care of our members. If the data shows that a particular provider organization is less efficient at providing and managing care than others, we typically use that data in an effort to negotiate a lower rate of increase. We will also seek to understand what providers are doing to become more efficient, and to work with them towards that goal. Negotiated rates of reimbursement also take into account other factors, including (i) quality of care, (ii) patient mix and intensity of services, (iii) geography, and (iv) market leverage. These are discussed in more depth in response to questions below. FCHP also deliberates how the negotiated rates will affect our customer's premiums prior to initiating a rate negotiation. It is imperative to FCHP that the resulting provider rates are at the lowest levels possible in order to effectively manage our members' premiums.
	Neighborhood Health Plan: When conducting provider contracting activities, NHP focuses on ensuring cost effective contracts are in place, with an added emphasis on the provision of quality services, as reflected in our consistently high HEDIS scores. Acute care hospital rates may be negotiated independently or as a component of an integrated health care delivery system. NHP's current reimbursement methodologies include: • per diem rate • case rate • discount from charge • fee schedule payments PCP's and Specialty Care Providers are reimbursed on the basis of NHP's standard fee schedule. Providers may negotiate a multiple of the base rates, which may be driven by the availability of the provider specialty, geographic accessibility or competitive pricing. We have one large multi-specialty group on a global payment contract. Skilled Nursing/Rehabilitation, Ambulatory Surgery Center, CHC, Urgent Care Center and all ancillary services are negotiated independently and the reimbursement methodology is standard across provider type. For any rate negotiation, the following factors are considered: Acute Care Facility considerations (in rank order of impact on negotiated rates) 1. For MassHealth members, reimbursement in the form of SPAD for inpatient services and PAPE for outpatient 2. Comparison to peers through plan level data as well as publically available cost and quality information 3. Types of services provided (i.e. specialty facility academic medical center, general services, integrated delivery system)

	4. Geographic location 5. Budgeted dollars available 6. Current or projected utilization by line of business Physician/Professional reimbursement considerations: 1. CHC vs. non CHC medical group practice 2. Medicaid and Medicare comparison 3. Comparison to peers 4. Types of service provided 5. Geographic location 6. Budgeted dollars available 7. Current or projected utilization Ancillary Provider reimbursement considerations: 1. CHC vs. non CHC medical group practice 2. Medicaid and Medicare comparison 3. Comparison to peers 4. Types of service provided 5. Geographic location 6. Budgeted dollars available 7. Current or projected utilization 8. Free standing services(i.e. urgent care, lab, radiology, etc) 9. Physician owned or independently entity
	Network Health: As a Medicaid Managed Care Organization (MMCO), Network Health develops its payment rates using the Massachusetts Medicaid fee schedules which include the SPAD (Standard Payment Amount Per Discharge) for facility inpatient services, PAPE (Payment Amount Per Episode) for the facility outpatient services, and the general Medicaid fee schedule for professional services. We use these rates as the starting point in our negotiations. However, providers generally assert that 100% of Medicaid reimbursement is insufficient to cover their costs. Since the beginning of the MMCO Program, reimbursing providers at a negotiated percentage over the Medicaid rates has been required to achieve adequate network access for enrollees. (Brief Summary)
	Tufts Associated Health Maintenance Organization: Tufts Health Plan strives to achieve the lowest reimbursement rates consistent with quality care for all provider negotiations. However, reimbursement rates can vary based on provider size, negotiation leverage, service uniqueness, and geographic location. The impact of these factors on negotiated rates is reinforced by the market pressure we face from employer groups and other purchasers to include all Massachusetts providers in our network.

Is there a material difference in how you approach	**BMC HealthNet**: The approach to contracting with a health care system tends to be more strategic than is typical of single facilities or group practices, given the added complexities of negotiating for a more comprehensive array of services housed under one "roof." Since health systems generally wield greater leverage than single providers, negotiated rates tend

contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group? [2]	to be higher. However, not all health systems have significant leverage. As suggested above, that leverage is influenced to a large extent (among other factors) by the availability of needed services, actual or perceived. A health system which offers little more than services already available within a region wields substantially less leverage, resulting in narrower gaps in region-wide provider pricing.
	CeltiCare Health Plan: As noted above, CeltiCare's approach to contracting for any provider type is to focus on high quality, low cost providers. Obviously when one is negotiating with a health system versus a single provider or facility there may be more issues to consider if a variety of services or multiple types of provider are involved and thus the actual negotiation may be more complex or take more time as both parties attempt to discuss and work through the myriad of issues, however, the basic focus on cost and quality does not change
	Fallon Community Health Plan: FCHP's major objective is to control the cost of care. The same data sources (depending on provider type) would be used whether contracting with an individual provider or a large integrated provider system. Certainly, a large health care system which comprises multiple hospitals, physicians, and various ancillary services (community based labs, PT, urgent care centers, etc.) tends to have more market clout than most individual provider entities. This market clout has to be taken into consideration when approaching a health care system since, in many geographic areas of the state, excluding this type of large health care system would not produce a viable health insurance product for the local individual and employer group markets. In addition, a single provider (hospital or physician group) that is geographically isolated from any competition also tends to have additional market clout. These entities leverage their geographic isolation during rate negotiations and sometimes can demand rates that are comparable to some of the very large integrated provider systems.
	Neighborhood Health Plan: Contracts with acute care hospitals are negotiated independently or are negotiated as a component of an integrated system. The negotiation of an integrated system has more complexity than a "standalone" hospital. Whereas NHP generally targets 60-120 days to negotiate contract terms, a health system can take longer because there are many more components that add complexities to the contract and therefore add time to the length of contracting cycle. There is often more of a mix or combination of reimbursement methodologies in an integrated system. There can be per diems, discount off charge, case rates and fee schedules. NHP's contracts cover all lines of business – CommonwealthCare, Commercial, and Medicaid.
	Network Health: Market leverage continues to play a significant role in the negotiations between providers and payers, even in the public market. Systems have greater leverage than small organizations and groups; this leverage is reflected in the fee-for-service rates agreed to by the parties. (Brief Summary)
	Tufts Associated Health Maintenance Organization: Tufts Health Plan strives to achieve the lowest reimbursement rates consistent with quality care for all provider negotiations. However, larger integrated health care systems tend to have greater leverage in negotiations since the level of disruption to our members is greater if we fail to reach agreement. Negotiations with these provider organizations require significant internal resources and greater contract flexibility.

[2] Testimony submitted by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and United Healthcare of New England was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic. [3]	**BMC HealthNet**: BMCHP's experience with its provider network supports your understanding of this dynamic, and is consistent with the recent findings of the State Attorney General with regard to those factors that influence provider leverage within the various markets and, consequently, reimbursement. Those providers who command the highest rates within BMCHP's network are those (a) whose market position is primarily influenced by geography, (b) who are highly specialized, and/or (c) who are publicly recognized as healthcare industry "leaders." At the same time, there appear to be no discernable factors (e.g., quality or efficiency) that distinguish these providers from most other providers, and which might otherwise merit a higher rate of reimbursement.
	CeltiCare Health Plan: The level of reimbursement paid to providers is based on a number of factors including the services they are able to offer, the cost structure associated with providing those services, the expertise of their staff, the specific types of specialty care offered, the case mix of the membership being treated and the availability of other providers with the same capabilities within a reasonable distance, among other things. When contracting with providers CeltiCare considers all of these factors and target network development efforts on those providers who are focused on offering high quality/lower cost alternatives to care
	Fallon Community Health Plan: For a commercial health plan to be viable, the network must include certain providers. This "must have" factor can be based on geographic isolation, the division of clinical services between neighboring hospitals, the real or perceived reputation for the providers' services, and/or types of tertiary service that few or no other providers can provide. For example, some geographic regions simply have higher costs, and these are reflected in the rates that providers in those regions demand. Geographic location may also provide greater negotiating leverage to certain providers where those providers are geographically isolated and where there are fewer qualified alternative providers. From time to time, FCHP may expand certain products into new geographic markets, where FCHP does not yet have a substantial number of members. In those situations, FCHP has less leverage in negotiating rates with the providers in those markets. There are other providers, both hospital and physician, who can demand higher reimbursement due to the type and breadth of services they offer, the number of hospital sites and physician sites they can deliver in a single negotiated deal, and their reputation as a center of excellence and/or cutting edge teaching hospital. An individual hospital or physician group may have one or more of these attributes but a large integrated system of hospitals, physicians, and ancillary providers typically exhibits more of these advantages. The more of these advantages an individual provider or an integrated system possesses, the more their negotiating power is increased and the end result is higher base reimbursement rates.
	Neighborhood Health Plan: NHP has a robust and comprehensive contracting approach that relies upon: • understanding provider and member needs • establishing clear access and availability standards • establishing reimbursement standards and cost projections • conducting ongoing network assessments The majority of NHP's commercial member population (and a significant portion of its Medicaid and CommCare membership) resides in the greater Boston area. This geographic composition of our membership can often create

[3] Testimony submitted by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and United Healthcare of New England was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

	additional cost pressures. For example, CHCs in the Boston area are important primary care partners. These sites provide high quality, culturally competent and cost efficient primary care throughout the metropolitan area. Because of the location of the CHCs, as well as the members' residence, Boston-based academic medical centers are often used for care that could be delivered at a community hospital, if one were proximate. As the availability of primary care and certain provider specialties continues to decrease, providers and their negotiating entities will continue to hold leverage in demanding higher levels of reimbursement. This is most readily demonstrated in the geographic expansion of specialty hospitals and academic medical centers into community care facilities outside the greater Boston area. Many community based physician organizations are contractually affiliated with the physician organizations of large academic medical centers and therefore reimbursed at the rates of those large physician organizations. In addition, many academic medical centers are expanding their reach into the suburbs. This is inflating a high base, making for very difficult contract renegotiations. With the advent of hospital systems becoming for profit, mergers, and acquisitions, NHP will continue to face greater challenges in being able to negotiate competitive rates.
	Network Health: While the demands for higher rates continue, MMCO rate re-negotiations and membership shifts have begun to change some of this dynamic in select markets. (Brief Summary)
	Tufts Associated Health Maintenance Organization: Providers that are geographically isolated, perform unique specialty services, or enjoy strong reputations tend to exhibit greater leverage in contract negotiations. These drivers of provider leverage are reinforced by member and employer demands for full access to providers, particularly those with national standing and the ability to perform advanced specialty services. This dynamic has always existed, but its impact on rate disparities has increased due to provider consolidation.

What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures? [4]	**BMC HealthNet**: It is appropriate to incorporate objective quality performance as a component of provider reimbursement. Current measures are often limited by small sample size, a lack of standardized specialty measures and a lack of clinical detail on claims.
	CeltiCare Health Plan: One approach to utilizing quality data is to base reimbursement upon performance of generally accepted quality measures with both upside and downside risk. Quality performance standards could be required to achieve certain reimbursement levels as negotiated within the substance of the contractual relationship, rather than as an upside addendum, and in the case of PCMHI, are required simply to maintain eligibility for participation in the pilot and continue to receive health plan payments in support participation. Quality measures could be helpful in protecting the consumer from underutilization in an era of payment reform where risk models may be shifting.
	Fallon Community Health Plan: Quality is difficult to measure accurately, yet it is important to continuously assess the data that is available. Therefore, FCHP collects across providers quality measures that are standardized and endorsed by national councils, federal quality agencies and accreditation organizations. FCHP is required to annually collect and submit data to NCQA on approximately 90 quality metrics. These metrics can be reviewed at the provider and patient level detail.

[4] Testimony submitted by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and United Healthcare of New England was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

	FCHP also participates in the Massachusetts Health Quality Partners (MHQP), which publicly reports quality measurements at the group practice level and individual practice sites across the state with aggregate scores from all health plans. The quality measurements that are currently in use have been endorsed by the National Quality Forum, an entity that has been supported by all of the private and public stakeholders. There has been consensus for several years that these quality metrics are the right types of measurements and national councils representing medical specialties have contributed to their development. The specifications for these indicators have been standardized across all health plans for benchmarking purposes as well as comparative evaluations. These quality measures have been used consistently for many years and continue to drive the national rankings for health insurance plans. These types of measurements also are used to evaluate wellness and preventive care, as well as chronic care management in the industry.
	Neighborhood Health Plan: Quality should play a role in determining price. The Massachusetts health care community collects the right types of quality measures that have been field tested and endorsed by national organizations (National Quality Forum, NCQA, and AHRQ). Quality measurement is extensively developed in some areas, such as primary care, and underdeveloped in other areas, such as dermatology and behavioral health.
	Network Health: To achieve high value care, payment should relate to cost and quality. (Brief Summary)
	Tufts Associated Health Maintenance Organization: Quality should be considered as a component of any global-based contract where improved efficiency is the desired outcome. However, the most helpful types of quality measures are not claims-based, but rather provider-generated outcomes.

Questions for Providers

What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices? [5]	**Boston Medical Center**: Price variation likely results from market leverage. Based on BMC's experience, the following factors are appropriate reasons for differentiated prices: socioeconomics of the patient population; patient acuity; required cross-subsidies among services and among payers; wage index differences; expenses associated with medical education. The primary determinant of price variation across Massachusetts is likely market leverage, which results from size, geographic location, and brand recognition/consumer perception of quality. The following factors are embedded in BMC's costs and do not affect other institutions to the same degree. They might be appropriate reasons for differentiated prices: • Socioeconomic factors: Because of its charitable and statutory mission and location BMC sees a disproportionate amount of low-income patients. This result has a profound impact on both its costs and revenue. Many of BMC's patients do not have insurance; do not speak English; have mental health issues

[5] Testimony submitted by Baystate Health, Cambridge Health Alliance, Family Health Center of Worchester, and Steward Health Care System was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

	and drug or alcohol dependence; and lack proper support at home or are homeless. BMC has to expend resources beyond what most hospitals spend to treat patients, such as for translation services (the largest in New England), outreach counselors to find insurance programs that the patient qualifies for, transportation services, social services, and special low-income programs to provide support after patients leave the hospital. • Higher wage costs (city/community; competitive labor market drives salary expense) • Expenses related to patient acuity • BMC's academic/teaching responsibilities • The need for cross-subsidies among services and among payers
	Brigham and Women's Hospital: As stated in our responses to Questions 1 and 15, we believe that an analysis of price variation to be fundamentally flawed when done on a service-by-service basis, which is not reflective of how hospitals manage their finances and does not account for how hospitals allocate and balance costs and revenues across service lines" (e.g., cross-subsidization). Price variation across health care providers is observed across the country, not just in Massachusetts, and is explained by many different factors. Hospitals and hospital services are not commodities but highly differentiated based on hospital characteristics such as teaching mission, location, quality, size, services, health of area population and those patients attracted to specific facilities, and labor and expenses associated with providing services. These factors are recognized, at least in part, by Medicare in its reimbursement formulas. Other important factors not recognized by Medicare but also contributing to costs include a hospital's payer mix, as well as its community investments. Indeed, the Division's report cited a number of the factors that Medicare considers in calculating reimbursement such as wages, new technologies, and outliers, then estimated the variation in Medicare "prices" for Massachusetts hospitals, compared it with variation for private payor prices, and concluded that "variation associated with these factors results in a range in Medicare prices that is similar in breadth to the range found in this report's analysis of private payer prices."[6] Detailed empirical analyses of factors explaining non-government "price" variation across Massachusetts hospitals by Dreyer and across Massachusetts and national data by Guerin-Calvert and Israilevich further confirm that "hospital prices are directly related to the costs of providing services to patients and their communities, including wages, capital investment, and the level and specialization of services."[7] Research does not demonstrate a basis for concluding that price variation is any greater in Massachusetts than it is elsewhere across the U.S. Finally, an important factor to recognize is that price variation occurs in competitively structured markets and is observed in markets with many competitors and low concentration; as a result, price variation does not in itself portend or reflect

[6] Executive Summary at p.3.

[7] Guerin-Calvert and Israilevich, "Assessment of Cost Trends and Price Differences for U.S. Hospitals," March 2011 at p. 3; see also, Guerin-Calvert and Israilevich "A Critique of Recent Publications on Provider Market Power" October, 2010 and Report of Paul Dreyer.

	"market power" problems. As was noted in an FTC Working paper: "[I]n a market with differentiated products [such as a hospital market], different price levels are neither necessary, nor sufficient, to demonstrate the exercise of market power."[8]
	Holyoke Medical Center: Price variation as defined in the Massachusetts Healthcare Cost Trends: Price Variation in Health Care Services states that, "prices paid by private health plans . . . and rates paid by Medicaid and Medicare" are driven by numerous factors including the ability to influence the markets by having a high-valued reputation or image which will influence payer and patient selection. This market clout deals more with patients' and insurers' desire for bigger institutions' and tertiary hospitals' for routine care. Markets can also be influenced by infusing significant money into advertising which also drives insurance carriers, providers, businesses and patients toward certain hospital providers. Chronically under-funded hospitals, like Holyoke, use their limited funds for patient care rather than advertising. Price variation also occurs through the calculation of the Medicaid SPAD and PAPE payments. Hospitals do not get paid the same by Medicare or Medicaid for the same services. Price variation may occur due to the availability of infrastructure and high-tech equipment and services. Prices can vary between community and teaching hospitals for Medicare and Medicaid payments because of the teaching status. Some private insurers also pay more for the availability of these teaching services. Price variation can occur because of socioeconomic reasons, acuity, multiple illnesses and morbidity, market clout, and patients' ability to comply with follow-up care. Prices can change by the availability of physician specialists or other high-tech personnel (which costs more). Holyoke has many socioeconomic factors affecting the community it serves and remains one of the lowest price and poorest paid hospitals in the state. It has little leverage with private insurers because of its small private pay population.
	Lowell General: LGH concurs with the DHCFP and the Attorney General's conclusion that market position and leverage is a principal driver accounting for a wide variation in payment rates to providers across Massachusetts. Market power, geographic isolation, economic development and political clout are the most important levers used during a negotiation of prices by a provider. Public perception and brand name are extremely important assets to bring to the negotiation table. Differences in acuity could account for differences in rates, and differences in measurable quality outcomes should justify some differentials. Further, LGH acknowledges the need for a differential in rates for teaching and research institutions. Medical education and research are cornerstones of the Massachusetts healthcare system. The training of future physicians is extremely important to all providers in Massachusetts. In addition to teaching programs, LGH acknowledges that higher cost structures are required to maintain transplant programs, clinical research programs and other leading edge research that takes place in many Massachusetts academic medical centers.
	Massachusetts General Hospital: As stated in our responses to Questions 1 and 15, we believe that an analysis of price variation to be fundamentally flawed when done on a service-by-service basis, which is not reflective of how hospitals manage their finances and does not account for how hospitals allocate and balance costs and revenues across service lines"

[8] Haas-Wilson, Deborah, and Christopher Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," Bureau of Economics, Federal Trade Commission, *Working Paper*, No. 294(2009), p. 9.

	(e.g., cross-subsidization). Price variation across health care providers is observed across the country, not just in Massachusetts, and is explained by many different factors. Hospitals and hospital services are not commodities but highly differentiated based on hospital characteristics such as teaching mission, location, quality, size, services, health of area population and those patients attracted to specific facilities, and labor and expenses associated with providing services. These factors are recognized, at least in part, by Medicare in its reimbursement formulas. Other important factors not recognized by Medicare but also contributing to costs include a hospital's payer mix, as well as its community investments. Indeed, the Division's report cited a number of the factors that Medicare considers in calculating reimbursement such as wages, new technologies, and outliers, then estimated the variation in Medicare "prices" for Massachusetts hospitals, compared it with variation for private payor prices, and concluded that "variation associated with these factors results in a range in Medicare prices that is similar in breadth to the range found in this report's analysis of private payer prices."1 Detailed empirical analyses of factors explaining non-government "price" variation across Massachusetts hospitals by Dreyer and across Massachusetts and national data by Guerin-Calvert and Israilevich further confirm that "hospital prices are directly related to the costs of providing services to patients and their communities, including wages, capital investment, and the level and specialization of services."2 Research does not demonstrate a basis for concluding that price variation is any greater in Massachusetts than it is elsewhere across the U.S. Finally, an important factor to recognize is that price variation occurs in competitively structured markets and is observed in markets with many competitors and low concentration; as a result, price variation does not in itself portend or reflect "market power" problems. As was noted in an FTC Working paper: "[I]n a market with differentiated products [such as a hospital market], different price levels are neither necessary, nor sufficient, to demonstrate the exercise of market power."3 1 Executive Summary at p.3. 2 Guerin-Calvert and Israilevich, "Assessment of Cost Trends and Price Differences for U.S. Hospitals," March 2011 at p. 3; see also, Guerin-Calvert and Israilevich "A Critique of Recent Publications on Provider Market Power" October, 2010 and Report of Paul Dreyer. 3 Haas-Wilson, Deborah, and Christopher Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," Bureau of Economics, Federal Trade Commission, *Working Paper*, No. 294(2009), p. 9.
	Mount Auburn Hospital: We believe that factors accounting for price variation include: geography, market leverage, payor mix, and underlying hospital costs (which would also factor in whether a teaching hospital and what services are offered). Prices could also vary based on contract cycles. When comparing specific services, prices could also vary by how specific services might have been treated in a negotiation.
	Sturdy Memorial Hospital: Some of the factors that may influence the price variation across Massachusetts providers include: 1) Special Payments – With the development of PHOs and ACOs, some costs, such as IT infrastructure, are paid for by the insurance companies through lump sum "infrastructure payments." We have been told that these

	payments are substantial ($3 million for an organization our size). Hospitals that are part of these PHO/ACOs may be willing to accept lower reimbursement rates in exchange for quality bonus payments or other lump sum payments outside of the normal reimbursements. 2) Business strategy – Some hospitals may take lower prices as part of a strategic business plan to increase volume. Others may feel forced to take lower rates to accommodate the needs of a capitated physician group or the pressure of an insurance company. 3) Limited services – Some hospitals may not offer services that are not profitable eliminating the need to subsidize those services while others may feel compelled to offer all services that are appropriate for their community, regardless of their profitability. 4) Economies of scale – Fixed costs spread over more volume would result in lower fixed cost per unit of volume. It is also possible that larger organizations are too big to operate efficiently in a continually changing environment. 5) Amount of uncompensated care – Services provided to those who cannot or will not pay, must be financed by those willing to pay. 6) Payer mix – Governmental payments are not sufficient to cover costs of providing care and must be subsidized by payments from private payers. 7) Medicare area wage index differences and other governmental payments and adjustments. 8) Postponing capital improvements – Some hospitals have put off necessary capital investment. The result is lower depreciation cost, which would contribute to lower rates, but the result is an unsustainable, aging plant. Hospital prices should reasonably support its overall operations including keeping necessary services such as OB, cardiac rehab and pediatrics available in a community even if they lose money.
	Tufts Medical Center: It is well known that quality at Massachusetts hospitals is outstanding compared to the rest of the country. There are differences in quality among institutions, but the Attorney General has shown that those differences bear no relation to how much providers are paid. The Attorney General's 2010 report clearly showed that the factors that most strongly influenced prices paid by insurers were brand-name recognition and market clout as well as geographic isolation. It has also been demonstrated that providers who treat more patients covered by government programs do not receive higher payments from commercial insurers to make up for the underpayment by the government. In fact, it has been shown that the more Medicaid patients a hospital treats, the lower its commercial reimbursements tend to be. We agree with those assessments. Several factors that *should* be recognized in differentiated prices are: Safety net and Medicaid mix Acuity – the severity of illness treated by the provider Teaching status – Academic Medical Centers bear a significant burden in training the next generation of physicians and other caregivers, and they also are required to maintain and provide a higher level of critical services essential to all communities.

	Quality – providers should be reimbursed for keeping patients healthy Efficient care management – providers who demonstrate efficiency in treating patients should not be penalized by well-below market rates.
	Acton Medical Associates: It is Acton Medical's belief that price variations across Massachusetts providers are due to the following factors: • **Technological and Clinical Capabilities:** Care that is of a more complex nature requiring riskier procedures and innovative treatments can result in higher costs. • **Market and/or Geographic Clout:** Third-party negotiations are greatly influenced by leverage factors including the number of patients associated with the providers' organization, its reputation, and its geographic location.
	Atrius Health: The breadth of the question and timing for response constrain our ability to do a comprehensive review, analysis, and response with respect to recommendations for systemic or policy changes. Set forth below are some comments based on our experience that we believe could be helpful in informing consideration of such changes in the future. Price variation for similar health care services may arise from these factors, all of which are reasonable to recognize in differentiating price: (i) Different payer approaches to contracting, (ii) Historical contract pricing and actual experience (iii) Geography; some areas are more expensive than others for real estate and labor, (iv) Different mix of services, size, staffing etc. and different infrastructure and other costs of doing business, (v) Quality of services provided, (vi) Ability of a provider to manage total case costs such that higher prices may be allowed for individual services, (vii) Use of different technology for the same services, (viii) Site of care – physician group, community hospital, academic medical center, specialty facility,

	(ix) Type of specialist performing the service, (x) Length of contract.
	Central Massachusetts IPA: Market power seems to be the principal driver currently of price variation across Massachusetts providers. Providers have market power in the following ways: (i) they control a large number of PCPs who are employed or affiliated with their system; or (ii) they are located in an isolated area where there is not much competition; or (iii) they provide a service so unique or specialized that payers need to include them in insurance products in order to make the products marketable. The only factors that should justify differentiation in prices are case mix and quality, with quality outcomes being compared among providers using standardized and objective measures.
	Fallon Clinic: In response to these questions we have assumed that the term "price" is synonymous with reimbursement rates. Fallon Clinic understands that the DHCFP and the Office of the Attorney General are concerned with the potential for an organization's market coverage to equate to an advantage in negotiating commercial payer reimbursement rates. We are not privy to what other medical practices are paid or what influences those rates, but we are in agreement that the rates should be similar for physician services of like quality provided to patients with like conditions and needs. In addition the costs that the practice has to bear needs to be taken into consideration when determining fair reimbursement. For instance, if a practice is working under a risk arrangement and, based on location and patient preference, the practice is dependent upon an Academic Medical Center for inpatient and certain ancillary care, that practice's costs are going to exceed those of a like practice that partners or aligns with a lower cost hospital. A second factor that should influence rates is the clinical demands associated with a particular practice's' patient mix – if a practice cares for a large population of chronically ill patients or those with high needs, its costs and corresponding reimbursement levels should reflect this. Finally, Fallon Clinic has made significant investments in programs and systems to monitor and improve quality, and to ensure the appropriate utilization of health services. The magnitude of these investments and the benefits derived by patients and payers are somewhat rare among multi specialty group practices in the Commonwealth. We apply the use of these quality and efficiency measures to all our patients without regard to the type of reimbursement, with the outcome being Fallon Clinic is among the top tier providers in terms of providing real value to patients and payers. It is our opinion that this level of effort and the resulting outcomes should be reflected in the price paid for services, especially because quality and efficiency lowers total cost for FFS patients, as well as for capitated patients. Overall, Fallon Clinic feels the differentiating factors associated with reimbursement rates are, in priority order; quality, patient experience and efficient provision of care. To achieve this outcome will require the development of measures that can account for the many variations in acuity, lifestyle issues and vendor costs. In addition, to move in this direction will require that policy at the local and national levels be modified to move from treating health care as a market-based commodity, where success can be determined by

	size and resources, to one that is based on value defined as those that provide the best quality and service at a reasonable cost. The patient needs to return to the center of any new equation that directs resources to providers.
	HealthAlliance with Physicians, Inc.: Market power seems to be the principal driver currently of price variation across Massachusetts providers. Providers have market power in the following ways: (i) they control a large number of PCPs who are employed or affiliated with their system; or (ii) they are located in an isolated area where there is not much competition; or (iii) they provide a service so unique or specialized that payers need to include them in insurance products in order to make the products marketable. The only factors that should justify differentiation in prices are case mix and quality, with quality outcomes being compared among providers using standardized and objective measures.
	Holyoke Health Center: In the area of primary care, payment should recognize the comprehensiveness of services and the complexity, including socio-economic complexity, of the patients served. Well chosen health outcomes, which take into account the health status of a patient entering care, are a reasonable measure of quality and could be included in a payment model. Finally, shared savings will offer opportunities to enhance primary care reimbursement, allowing for further innovation in care delivery and adequate salaries and benefits to recruit health care team members into primary care.
	Metrowest Health Care Alliance: Partners Healthcare has been a major driver in the rise of our healthcare costs.
	Mount Auburn Independent Physicians: Market clout based on the size of integrated delivery system and geographic isolation accounts significantly for price variation across MA providers. Other factors that should be taken into account for pricing include performance in quality measures and preventive services provided by the contracting organization.
	New England Quality Care Alliance: It is well known that quality at Massachusetts hospitals is outstanding compared to the rest of the country. There are differences in quality among institutions, but the Attorney General has shown that those differences bear no relation to how much providers are paid. The Attorney General's 2010 report clearly showed that the factors that most strongly influenced prices paid by insurers were brand-name recognition and market clout as well as geographic isolation. It has also been demonstrated that providers who treat more patients covered by government programs do not receive higher payments from commercial insurers to make up for the underpayment by the government. In fact, it has been shown that the more Medicaid patients a hospital treats, the lower its commercial reimbursements tend to be. We agree with those assessments. Several factors that *should* be recognized in differentiated prices are: Safety net and Medicaid mix Acuity – the severity of illness treated by the provider

	Teaching status – Academic Medical Centers bear a significant burden in training the next generation of physicians and other caregivers, and they also are required to maintain and provide a higher level of critical services essential to all communities. Quality – providers should be reimbursed for keeping patients healthy Efficient care management – providers who demonstrate efficiency in treating patients should not be penalized by well-below market rates.
	Pioneer Valley Surgicenter: There are numerous reasons why cost variations occur across similar healthcare service lines. To name a few: 1. Smaller ASC's are not able to leverage comparable pricing on medical supplies, insurance contracting, and other services. Larger entities, such as HOPD's (Hospital Out-Patient Departments) continue to leverage improved pricing despite the disparity of charges and reimbursement. Refer to response in Question 1. 2. When services are restricted from development in certain geographic areas such is the case in the current ASC DON regulations and guidelines, a monopoly is allowed to thrive which inherently increases cost and restricts consumer choice. Refer to Question 2 regarding patient co-payment responsibilities. The other aspect of this utilization issue that is important is in reference to the legislative burden that has been placed on ASC's in Massachusetts. Since 1995, the Department of Public Health (DPH) Determination of Need (DON) Programs has had a "no need, no file" policy for freestanding multispecialty ASC's. This means, in essence, do not bother filing, you will not be allowed to build. Single specialty ASC's have faced similar obstacles and efforts by the MAASC to repeal these restrictions have been fruitless. This, therefore, bears a clear correlation with Massachusetts having higher health care expenditures and utilization of HOPD's when compared with the rest of the nation. The legislation limits competition. By repealing this antiquated legislation, Massachusetts will be able to take advantage of our inherent cost savings.

We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation in prices for hospital care does not appear to represent any corresponding gain in quality	**Boston Medical Center**: BMC does not believe that price is yet correlated with quality. In addition, BMC recommends that pay for performance (P4P) programs be created cautiously, because they may be biased in favor of providers who receive adequate rates. Such providers can create the infrastructure needed to demonstrate they are meeting quality outcomes. For example, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results improve with a telephone call to the patient after discharge. Among BMC's patient population, however, telephone contact with patients after discharge can be unreliable. Moreover, wealthy systems can afford adding the additional human resources necessary for this outreach, others cannot.
	Brigham and Women's Hospital: We believe that prices are correlated with quality, and that the Division's inability to find a correlation in its analysis is no reason to believe that such a correlation does not exist and speaks to the inadequacy of current quality measures. Indeed, the Division acknowledges in its report that its findings may be an indication that "publicly available measures are not sensitive enough to discern difference amongst Massachusetts hospitals."[10]

based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality? What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures? [9]	At least one out of every six patients at the MGH, and at least one out of every eight at the Brigham, is transferred from another, non-Partners hospital in the hope that we can provide unique life-saving care. These are the very sickest patients – and, sadly, despite our very best efforts, they are four out of every ten of our deaths at BWH and nearly half of our deaths at the MGH. Providing this care is essential to our mission, but we recognize that these factors adversely affect our hospitals' cost and quality data. We strongly believe that our hospitals' reputations for providing the best care in the most extraordinary circumstances speaks to the quality of the care that we provide in a way that no process measure ever could. There are two issues intertwined in this question – the ability of existing quality measures meaningfully, comprehensively, and in a strictly quantitative way to reflect important differences among providers, and the significance and sources of price variation. On the first issue, we would note that most of the existing quality measures that are commonly used to compare providers are process measures for which there is a strong evidence base. While we believe these measures focus on important processes, the very nature of these measures renders them inadequate for differentiating excellent from competent care. These measures have become nationally-recognized measures because they are (1) not controversial, and (2) largely under the control of individual physicians and hospitals. Hence, virtually all competent providers are familiar with them, and are performing these processes. Massachusetts is fortunate to have many competent hospitals and physicians and performing well on these measures is expected. As a result, it is unclear that one should expect many or all of these measures to have wide variation across hospitals, particularly where they are more readily achievable by a broad range of organizations, or for their variance to track that of prices, which reflect a far broader array of factors. However, most of these measures do not reflect the more complex interactions among groups of physicians, or between hospitals and physicians, that lead to outcomes that are valued by patients. Nor do they account for the complexity of cases, both medically and socioeconomically. Some "system" measures do exist, such as hospital readmissions. Others are in early forms, such as measures of the extent to which physicians are aware of what other physicians are communicating to patients, which greatly affects patients' experiences of care. Ironically, existing measures were developed for a fragmented U.S. health care system, and are metrics that measure performance at the individual entity level and thus do not capture what systems really do. As we noted earlier in our response to question #5, variance in price exists in all U.S. health care marketplaces, and is not correlated with overall price trend. It is important to recognize that policies that aim simply to accomplish a reduction in price variance are unlikely to reduce overall price (cost) trend, and in fact can be expected to have unintended consequences such as elimination of services that as a result are reimbursed below costs from the marketplace.
	Holyoke Medical Center: Holyoke does not believe that price is directly related to quality as shown in the recent studies by the Attorney General and The Division of Health Care Finance and Policy. As previously stated in question #5, we believe that pricing is more dependent on facility image, market clout, the influence of employers, the number of patients that can be insured, and the desirability of the community they are insuring, etc. Holyoke believes that to provide high-

[9] Testimony submitted by Baystate Health, Cambridge Health Alliance, Family Health Center of Worchester, and Steward Health Care System was not available in a format that allowed it to be copied into this document. To view their responses please visit http://www.mass.gov/dhcfp/costtrends.

[10] *Price Variation in Health Care Services*, DHCFP, May 2011, p. 46.

	quality there is a baseline cost. Beyond that baseline cost there are many other costs which are not related to quality such as marketing plush environments, valet parking, custom meals, soft music, etc. In addition, Holyoke believes that consumers do not know how to differentiate between high-quality care and "baseline" care. They don't know if the laparoscopic incision should require three stitches or five stitches. Rather, consumers base their perception of quality on the friendliness of staff, initial greeting, how shiny the floor is and if there are soothing colors on the walls and curtains. The obstetrical quality data and price ratio as outlined in the Price Variation in Healthcare Services Report indicates that Holyoke has high quality of care for vaginal deliveries at a low cost. We believe that this assertion is correct. The reason as to why other hospitals have higher rates and lower quality is because some hospitals have more market clout and a better payer mix Holyoke believes that higher quality standards of patient care should be rewarded. We need to be careful to ensure that quality is collected and reported in a standardized manner and all definitions of quality are the same. In addition, the facility should only be held responsible for what it controls. Holyoke cannot affect readmissions from nursing homes or other providers when it has no impact on the care that the patient is receiving during the prior 30-day period. Hospitals should not be held accountable for quality issues that arise after a patient is discharged due to the lack of available facilities, the lack of contracted services by a particular payer for services such as nursing homes, visiting nurse services or appropriate psychiatric services or the lack of patient compliance. The recently initiated STAAR program may have some impact on avoidable readmissions.
	Lowell General: LGH would have no basis other than the Report to reach a conclusion that higher cost does or does not equate to higher quality. LGH is, however, a great example of an organization that has worked tirelessly on improving its reputation and brand, improving the quality of care it provides, and investing in its facilities to expand the scope of services to keep patients local. LGH has been able to do all this while consistently being paid in the lowest quartile of rates among other community hospitals. LGH cannot opine that high cost equals high quality, but we are proof that high quality does not have to mean high cost. LGH believes that quality should play a critical role in determining prices. Further, we believe that the health plans should follow BCBSMA's example and provide a significant portion of payments based on achieving quality benchmarks. LGH has attempted to contract with other health plans so that they would provide meaningful quality payments, but it has met with limited or no success. Health plans, other than BCBSMA, have not valued quality to the level we would like and believe it should be valued. Moreover, the quality component of the AQC provides the counterbalance to utilization management programs. The AQC quality program is designed to prevent disease, manage chronic conditions in the outpatient setting and manage patients that need inpatient care. In addition, the AQC places heavy weight on outcome measures and patient experience measures. LGH believes that, if the industry could agree on a consistent measure set across all private and governmental payers, there would be both a significant cost reduction and a quality improvement benefit.
	Massachusetts General Hospital: We believe that prices are correlated with quality, and that the Division's inability to find a correlation in its analysis is no reason to believe that such a correlation does not exist and speaks to the inadequacy of current quality measures. Indeed, the Division acknowledges in its report that its findings may be an indication that "publicly available measures are not sensitive enough to discern difference amongst Massachusetts hospitals."4

	At least one out of every six patients at the MGH, and at least one out of every eight at the Brigham, is transferred from another, non-Partners hospital in the hope that we can provide unique life-saving care. These are the very sickest patients – and, sadly, despite our very best efforts, they are four out of every ten of our deaths at BWH and nearly half of our deaths at the MGH. Providing this care is essential to our mission, but we recognize that these factors adversely affect our hospitals' cost and quality data. We strongly believe that our hospitals' reputations for providing the best care in the most extraordinary circumstances speaks to the quality of the care that we provide in a way that no process measure ever could. There are two issues intertwined in this question – the ability of existing quality measures meaningfully, comprehensively, and in a strictly quantitative way to reflect important differences among providers, and the significance and sources of price variation. On the first issue, we would note that most of the existing quality measures that are commonly used to compare providers are process measures for which there is a strong evidence base. While we believe these measures focus on important processes, the very nature of these measures renders them inadequate for differentiating excellent from competent care. These measures have become nationally-recognized measures because they are (1) not controversial, and (2) largely under the control of individual physicians and hospitals. Hence, virtually all competent providers are familiar with them, and are performing these processes. Massachusetts is fortunate to have many competent hospitals and physicians and performing well on these measures is expected. As a result, it is unclear that one should expect many or all of these measures to have wide variation across hospitals, particularly where they are more readily achievable by a broad range of organizations, or for their variance to track that of prices, which reflect a far broader array of factors. However, most of these measures do not reflect the more complex interactions among groups of physicians, or between hospitals and physicians, that lead to outcomes that are valued by patients. Nor do they account for the complexity of cases, both medically and socioeconomically. Some "system" measures do exist, such as hospital readmissions. Others are in early forms, such as measures of the extent to which physicians are aware of what other physicians are communicating to patients, which greatly affects patients' experiences of care. Ironically, existing measures were developed for a fragmented U.S. health care system, and are metrics that measure performance at the individual entity level and thus do not capture what systems really do. As we noted earlier in our response to question #5, variance in price exists in all U.S. health care marketplaces, and is not correlated with overall price trend. It is important to recognize that policies that aim simply to accomplish a reduction in price variance are unlikely to reduce overall price (cost) trend, and in fact can be expected to have unintended consequences such as elimination of services that as a result are reimbursed below costs from the marketplace. 4 *Price Variation in Health Care Services*, DHCFP, May 2011, p. 46.
	Mount Auburn Hospital: We support the inclusion of quality indicators as one factor in determining price. To date we have negotiated some prices which vary according to performance on quality measures and have found that this influence on price has become a larger factor over time. We don't think that price will ever correlate 100% with quality and probably should not factor in significantly until the measures are well established and performance uniformly measured. Established measures that are both strategically and technically relevant, outcomes based, and nationally endorsed are valid for inclusion in incentives and pricing.

	Sturdy Memorial Hospital: We believe that there is some relationship between quality and price as hospitals must have the necessary resources to provide quality care. Hospitals should have adequate fiscal resources to hire and retain appropriate staffing levels and invest in proven technological resources. According to a study recently published in the journal **Health Services Research**, increased spending on Medicare services translates to better overall health for beneficiaries. The study of more than 17,000 Medicare enrollees concluded that for every 10 percent increase in medical spending, there was a 1.9 percent improvement in the patient's overall health, and a 1.5 percent increase in the patient's probability of survival.
	Tufts Medical Center: While a number of insurance products incentivize providers to reach quality goals with additional payments for achieving benchmarks, these incentive payments tend not to change the underlying rates paid to providers, and hence they have yet to do anything to change the inequities among providers in this market. We do think that providers should be rewarded for high quality and incentivized to provide high-quality care, but underlying price differentials that are unrelated to quality must still be addressed. To be most effective in correlating prices with quality, improvements in the measurement systems need to occur. Very importantly in ambulatory care is moving from quality metrics based on claims to metrics based on actual clinical information from electronic medical records.
	Acton Medical Associates: The quality of care improves at high cost facilities for complex care, riskier procedures and difficult diagnoses as this type of care merits more specialized and innovative treatments. It is Acton Medical's belief that higher costs correlate with these types of treatment. However, for routine care that can be provided at the community hospital level, there should be no quality difference.
	Atrius Health: The breadth of the question and timing for response constrain our ability to do a comprehensive review, analysis, and response with respect to recommendations for systemic or policy changes. Set forth below are some comments based on our experience that we believe could be helpful in informing consideration of such changes in the future. <u>Price correlation with quality:</u> We believe that our quality, although not the only factor considered, has been a strong consideration in the pricing that we have established with the commercial payers. Atrius Health consistently rates among the leaders when clinical quality performance is evaluated by the health plans and Massachusetts Health Quality Partners. However, we do not believe that the quality of hospital services as measured today tracks closely with the hospital price for services, generally speaking. Certainly, more prosperous hospitals can afford to invest more in quality initiatives and therefore have higher scores, although usually the differences are marginal. We know that we have situations where the same surgeons operate at two different facilities with very different hospital pricing and likely very similar quality levels. <u>Role of quality in pricing</u>: We agree with the current direction of payers to link quality with payment rates and would like to see this trend move faster. The BCBSMA Alternative Quality Contract is a good example of explicitly tying financial

	incentives to improved quality; we are supportive of this methodology where meaningful "upside" is available for improved quality performance. We do not agree with the methodology proposed in the Medicare Shared Savings Program to use quality scores as a lever to decrease shared savings or shared losses. We do agree with CMS that not paying for serious errors is the proper direction, and that should be intensified as better metrics become available. As we move to increase quality, we believe that lower costs and better quality can move together using methods such as Lean process improvement to reduce waste, using prevention and good management of chronic disease to reduce hospital admissions, improving quality of the hospital stay and transitions to reduce re-admissions, etc. When this is done over time, rather than as a sudden cut, providers can take actions that will both reduce cost and increase quality. Quality Measures: The ambulatory quality measures that are currently collected represent some of the right outcome measures. However, they are largely focused on primary care and do not measure quality in the specialties. Furthermore, the quality measures do not measure appropriate utilization. We believe that the current state of quality measures for hospitals are woefully inadequate and therefore are at best crude measures of performance. The CMS hospital scores have been unchanged for years and measure only quality performance on the surface for a limited number of conditions. Much more extensive measures which would include specific outcomes for specific procedures/conditions would be a good start. More focus on transitions of care, care integration, readmission rates, and serious adverse event reporting would be welcome.
	Central Massachusetts IPA: CMIPA does not believe that the wide variation in price for hospital care is related to quality. But we also must acknowledge that quality has to be measured and we cannot improve what we cannot measure. Sound quality measurements that focus on outcomes, and not processes, should play a critical role in determining prices. The health care community does not currently collect the right types of quality measures because it is focused on "processes" rather than "outcomes," and has not figured out a way to measure specialists' performance. Outcome measures should attempt to capture the overall impact of multi-dimensional treatment strategies, which are critical in managing chronically ill patients. What we should measure varies, but it should include clinical data managed at the physician practice. It should also include time spent by the PCP that is not reimbursed, whether it is for the direct benefit of the patient or to meet the administrative burdens, and associated costs, placed on the PCP. The quality of all health care begins with the patient - PCP relationship. A PCP's ability to provide care that considers patient preference, cost and insurance coverage, as well as the underlying medical decisions, requires collaborative discussions that take time, but lead to good decisions that reduce cost and improve quality. Time is a valuable commodity, and the current payment system incents quantity, not quality. Couple this with time the PCP must devote to navigating a confusing payment structure and cumbersome billing process, which varies based on each payer and facility, and you have a system that does not allow the time for these important conversations to take place.

	Examples: 1) It is quicker to refer a patient to a specialist, than to take the time to explain options and possible solutions during an office visit that has a low reimbursement. It is more cost effective for the provider to see the next patient. 2) Diabetic patients need regular office visits, but contact and activities between office visits are what keeps the patient on track and out of more expensive facilities. Yet these activities are not reimbursed. Providing information regarding the true cost of care, as well as providing for a strong infrastructure to allow PCPs to measure and monitor their own clinical data, will lead to improved patient care, better decision making and higher quality and lower costs. It all begins with the conversation between the patient and the physician, a conversation the current payment structure does not facilitate and actually even limits in part due to the administrative burdens it places on the PCP.
	Fallon Clinic: It is difficult for providers to respond to questions about price. In Fallon Clinic's circumstances, where the preponderance of income comes from some form of prepayment and what fee schedules we have are negotiated outcomes, we really do not know how we compare to others in this regard. We can infer it, but we cannot know it. Even when through our capitation agreements we pay other providers (hospitals, physicians and other services), we do not usually know the prices for various services we purchase except through review of reconciliations. We do not believe price correlates very directly with quality in the Commonwealth. For example, we believe that our negotiated contract fee schedules for most products are substantially below what other similar groups have negotiated, and we are among the leaders in published quality measures. The measures themselves tend to be process measures with variable evidence linking them to patient outcomes, which is a major deficit of measuring quality in healthcare services. Clearly there is much to be done in the measurement or even the definition of quality in healthcare. For many consumers, quality is equivalent to brand and reputation into which a variety of non-relevant factors play.
	HealthAlliance with Physicians, Inc.: CMIPA does not believe that the wide variation in price for hospital care is related to quality. But we also must acknowledge that quality has to be measured and we cannot improve what we cannot measure. Sound quality measurements that focus on outcomes, and not processes, should play a critical role in determining prices. The health care community does not currently collect the right types of quality measures because it is focused on "processes" rather than "outcomes," and has not figured out a way to measure specialists' performance. Outcome measures should attempt to capture the overall impact of multi-dimensional treatment strategies, which are critical in managing chronically ill patients. What we should measure varies, but it should include clinical data managed at the physician practice. It should also include time spent by the PCP that is not reimbursed, whether it is for the direct benefit of the patient or to meet the administrative burdens, and associated costs, placed on the PCP.

	The quality of all health care begins with the patient - PCP relationship. A PCP's ability to provide care that considers patient preference, cost and insurance coverage, as well as the underlying medical decisions, requires collaborative discussions that take time, but lead to good decisions that reduce cost and improve quality. Time is a valuable commodity, and the current payment system incents quantity, not quality. Couple this with time the PCP must devote to navigating a confusing payment structure and cumbersome billing process, which varies based on each payer and facility, and you have a system that does not allow the time for these important conversations to take place. Examples: 1) It is quicker to refer a patient to a specialist, than to take the time to explain options and possible solutions during an office visit that has a low reimbursement. It is more cost effective for the provider to see the next patient. 2) Diabetic patients need regular office visits, but contact and activities between office visits are what keeps the patient on track and out of more expensive facilities. Yet these activities are not reimbursed. Providing information regarding the true cost of care, as well as providing for a strong infrastructure to allow PCPs to measure and monitor their own clinical data, will lead to improved patient care, better decision making and higher quality and lower costs. It all begins with the conversation between the patient and the physician, a conversation the current payment structure does not facilitate and actually even limits in part due to the administrative burdens it places on the PCP.
	Holyoke Health Center: As a primary care organization, we cannot speak to hospital costs. However, we believe that quality is very important is establishing price in primary care. Because we offer a wide range of services to an underserved, impoverished population in a culturally competent setting with translation services available at every encounter, our costs will necessarily be higher than a practice which offers only traditional doctor-patient medical care. Global payments on the front end, coupled with well chosen quality outcome measures, and shared savings after care delivery could combine to adequately reimburse and support this medical home model. With shared savings based on actual costs saved this model could guarantee cost savings. However, if most shared savings goes to insurers already enjoying record profits, there will be little incentive for primary care practices to make the substantial investments in staff, delivery system redesign, and information technology necessary to achieve savings. As a community health center, we are a nonprofit organization driven by mission and commitment to care for the underserved. Dollars generated by an adequate payment model go to providing a broader range of care, funding innovations in care, and paying our providers and staff salaries which will recruit and retain excellent caregivers.
	Mount Auburn Independent Physicians: Price and quality are not necessarily related. Quality should have a more prominent role in determining price since achieving high quality involves resources and money. Most physicians are in private practice working in small offices of one to four physicians. Creating the systems that are needed to achieve high quality is expensive and requires an infrastructure, such as an IPA, to support the physicians – electronic health records and health information exchange are just beginning and require experienced IT staff to support them. Registries and a

	data warehouse with analysts who can provide good reports that will be accepted by physicians take time and talent. Often, the right information is not collected by the health care and insurance industries or regulators. On the inpatient side, price does not relate to quality. Hospitals and physicians should be paid with a base rate, to which is added incentives for quality improvement and other components such as care management programs, supporting patients through transitions of care. Ambulatory measures are lacking, e.g., transitions from hospital to home, acute rehab or SNF. HEDIS measures are inadequate for these. There should be HEDIS measures on appropriate antibiotic use; for example, assessment of Bronchitis is based on how the physician codes, rather than the appropriate use of antibiotics.
	New England Quality Care Alliance: While a number of insurance products incentivize providers to reach quality goals with additional payments for achieving benchmarks, these incentive payments tend not to change the underlying rates paid to providers, and hence they have yet to do anything to change the inequities among providers in this market. We do think that providers should be rewarded for high quality and incentivized to provide high-quality care, but underlying price differentials that are unrelated to quality must still be addressed. To be most effective in correlating prices with quality, improvements in the measurement systems need to occur. Very importantly in ambulatory care is moving from quality metrics based on claims to metrics based on actual clinical information from electronic medical records.
	Pioneer Valley Surgicenter: ASCs are lower cost than HOPDs and provide equal or better quality and patient satisfaction. We strongly support a value based payment system that rewards these attributes, provides complete transparency on payment and quality as further detailed in recommendations presented to CMS in June 2010 by the ASC Association.
	Whittier Street Health Center: Community health centers are proof that price is not correlated with quality. Health centers provide cost effective yet high quality care to populations that are often the most difficult to engage in health care services. According to the Health Resources and Services Administration's Report to Congress on Efforts to Expand and Accelerate Health Center Program Quality Improvement: "A key driver of success for the Health Center Program to date has been its ability to demonstrate the value and quality of health center care and services to funders, payers and patients. Recent research substantiates health centers' success in increasing access to care, improving quality and health outcomes for patients, reducing health disparities, containing health care costs, and even serving as critical economic engines for their own communities." Furthermore, the report notes: • Patients who receive a majority of their medical care at a community health center have significantly lower medical expenses than do people who receive the majority of their care elsewhere. Medical expenses for health center patients are 41 percent lower ($1,810 per person annually) compared to patients seen elsewhere. • Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere.

	• Health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care. Increasingly, community based primary care is being looked at as an important part of the solution to escalating health care costs. While Whittier is a mission driven organization, it is also a business. Given our payer mix and low level of bargaining power for reimbursement, we are limited in our financial resources, yet quality of care delivery is not compromised. We are able to achieve primary care based clinical outcomes on par or better than many teaching hospitals in the area with fewer resources. For example, the percentage of low-birthweight babies delivered through Whittier's OB/GYN department in 2010 was 3% compared to a citywide average of 9% (2008) and an average of 12.3% in Roxbury (2007), our primary service area. Quality should have an important role in determining price and the right measures are most likely being collected, yet not fully utilized.

ATTORNEY GENERAL'S EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)

JULY 29, 2011

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

ONE ASHBURTON PLACE • BOSTON, MA 02108

TWO KEY QUESTIONS

1. **How can we improve market function?**

2. **How can we improve care coordination?**

RECOMMENDATIONS

1. Promote tiered and limited network products to increase value-based purchasing decisions.
2. Reduce health care price distortions through temporary statutory restrictions until tiered and limited network products and commercial market transparency can improve market function.

RECOMMENDATIONS

3. Encourage consumers to select a primary care provider who can assist consumers in coordinating care based on each consumer's needs and best interests.
4. Promote coordination of patient care through primary care providers by recognizing the need to improve funding of care coordination, including the infrastructure necessary to coordinate care, and by giving providers timely access to relevant patient data regardless of their size or payment methodology.

RECOMMENDATIONS

5. Consider steps to improve the use of the all payer claims database ("APCD") by: (i) developing reports for providers and the public to guide development of patient care coordination improvements and system accountability, and (ii) increasing the standardization of claim level submissions by reducing differences in how payers report payment level information.
6. Develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations.

Special Commission on Provider Price Reform

July 29, 2011

Agenda

- Stakeholder feedback
- Draft principles
- Analytic findings and additional requested analyses
- Recommendations by the Office of the Attorney General
- Potential strategies to reduce disparities in payment rates
- Recent proposals to address price variation
- Next steps

Stakeholder Feedback

Review of Draft Principles

1. Provider prices may vary for justifiable reasons.
2. Information regarding provider prices, underlying costs, and justifiable factors for variation should be available to support on-going provider price reform and monitoring.
3. Prices and the justifiable factors for variation should be transparent and communicated in a manner easily understood by consumers.
4. State government should take necessary steps to improve health care market functionality if market processes are resulting in increasing health care spending and/or unjustified price variation.
5. Any strategy to reduce the variation in provider prices must contain health care costs.
6. Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
7. Unjustified variation in provider prices should be reduced responsibly, and changes should be evaluated for intended and unintended consequences.

Price Variation Analyses

Summary of Findings

Correlation Analysis	Payer	R-squared	Correlation Strength
Quality	No statistically significant relationship observed		
Acuity (inpatient only)	BCBS Inpatient	0.2307	Weak
Payer Mix / Disproportionate Share Status	BCBS Inpatient	0.1236	Weak
	BCBS Outpatient	0.1324	Weak
	THP Inpatient	0.2307	Weak
	THP Outpatient	0.0999	Weak
Provision of Specialty Services	BCBS inpatient	0.1967	Weak
	THP inpatient	0.2050	Weak
Provision of Community Services	No statistically significant relationship observed		
Costs per CMAD (inpatient only)	BCBS inpatient	0.1789	Weak
	THP inpatient	0.1572	Weak
Teaching Status	BCBS inpatient	0.1809	Weak
	THP inpatient	0.1364	Weak
Volume (inpatient only)	BCBS inpatient	0.1415	Weak
	THP inpatient	0.1966	Weak

Includes statistically significant correlations only.

Price Variation Analyses

Summary of Findings

- Although some weak and moderate correlations were found, none of the factors analyzed were independently found to be significant predictors of higher or lower provider prices.

- In the absence of quantifiable relationships, it is reasonable to conclude that prices appear to be strongly influenced by other unexamined factors.

Additional Requested Analyses

Medical Loss Ratios

- From 2007 to 2009, the medical loss ratio (MLR) calculated across all group sizes increased from 88% to 91%. MLRs are greatest for individual market and generally lowest for small group market.
- Contribution to surplus (for not-for-profit companies) or profit (for "for-profit" companies) accounted for roughly 25% of retention charges built into pricing in all insured market sectors in April 2010.

	2007	2008	2009
Individual Pre-Merger Products	96.0%	95.2%	103.1%
Individual Post-Merger Products	105.6%	111.6%	108.9%
Individual Total	98.1%	107.1%	108.4%
Small Group	86.7%	86.5%	87.8%
Merged Market Total	87.1%	88.5%	90.1%
Mid-Size Group	86.9%	87.7%	89.9%
Large Group	89.5%	89.4%	92.0%
Total	87.9%	88.5%	90.6%

Division of Health Care Finance and Policy 2011 Cost Trends Report, *Premium Levels and Trends in Private Health Plans, 2007-2009*, May 2011. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/premium_report.pdf (last accessed 7/7/2011).

Summary of Hospital Price/Payment Variation with Specialty Excluded

Payer	Variation within Network	Variation, excluding specialty hospitals	Variation, excluding specialty and island hospitals
BCBS (Inpatient)	165%	110%	101%
BCBS (Outpatient)	222%	222%	147%
THP (Inpatient)	955%	932%	600%
THP (Outpatient)	268%	266%	168%
HPHC (Blended)	389%	389%	267%

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).
Excluded specialty hospitals are Children's Hospital, Dana-Farber, and Massachusetts Eye and Ear. Island hospitals are Martha's Vineyard and Nantucket Cottage.

Summary of Physician Group Price/Payment Variation with Pediatric Excluded

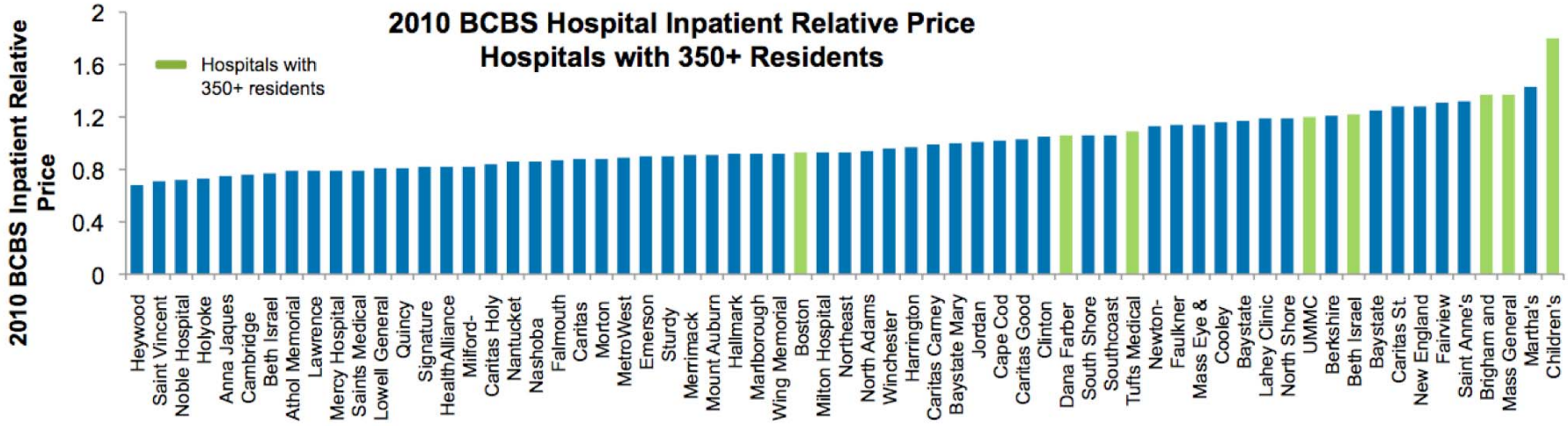
Payer	Variation within Network	Variation, excluding pediatric practices
BCBS	225%	80%
THP	177%	56%
HPHC	184%	106%

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011).
Pediatric practices include Children's Hospital PHO.

Teaching status is weakly correlated with inpatient price for two payers

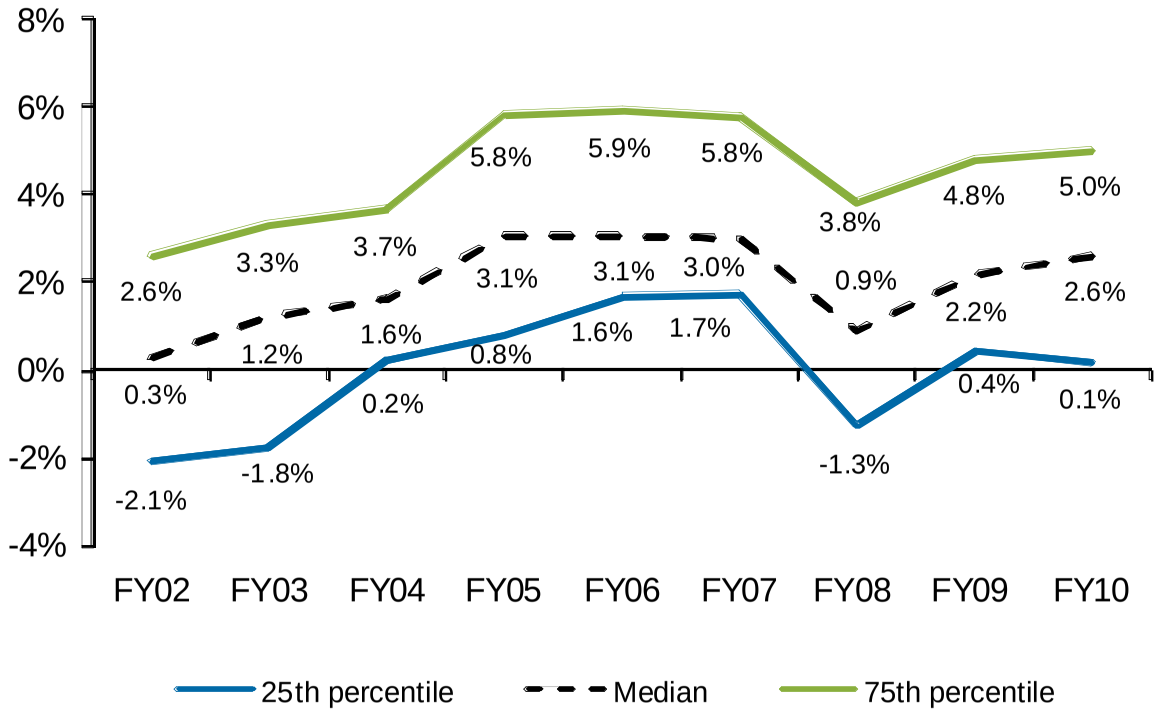
	R^2, Teaching Status (Y/N) > 25 resident FTEs: 100 beds	R^2, Teaching Status (Y/N) Hospitals with 350+ Residents	R^2, Ratio of FTE residents : 100 beds
BCBS inpatient relative price	0.1809 *	0.2036*	0.0184
BCBS outpatient relative price	0.0322	0.1048*	0.0319
THP inpatient relative price	0.1364 *	0.2249*	0.0302
THP outpatient relative price	0.0111	0.0680*	0.0004
HPHC relative payment (total)	0.0007	0.0244	0.0094

* Indicates statistical significance at p-value <0.05



SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). Available at: mass.gov/dhcfp/costtrends (last accessed 7/7/2011). Data regarding FTE residents per 100 beds from 2010 DHCFP-403 hospital cost reports. Hospitals with 350+ residents include MGH, BWH, BIDMC, BMC, Tufts, DFCI, UMMC, and Children's.

Acute Hospital Total Margin



Note: Total margin is the ratio of total income to total revenue.

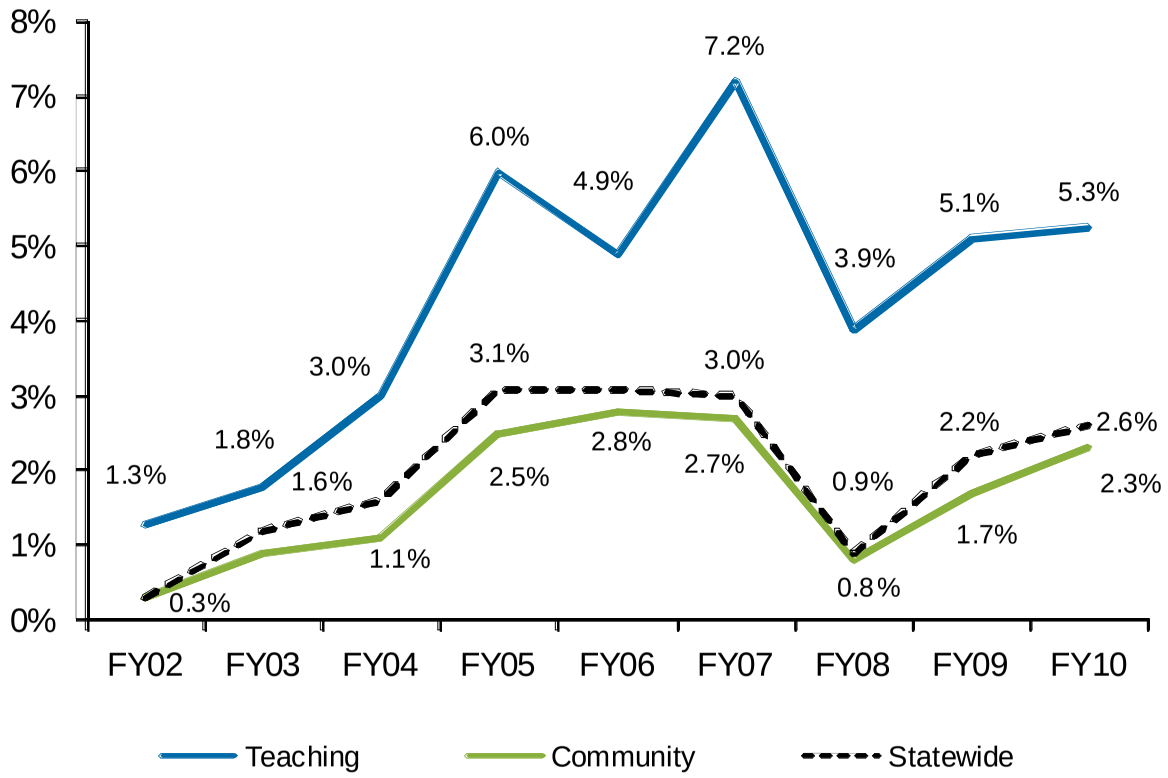
The median total margin improved in FY10 to 2.6%, though more hospitals reported a negative total margin than in FY09.

In FY10, sixteen out of sixty-five hospitals (24.6%) reported a total loss compared with thirteen hospitals (20.0%) during FY09.

Benchmark: Northeast US median FY08 = 0.9%

Benchmark Source: 2010 Almanac of Hospital Financial and Operating Indicators, INGENIX

Teaching and Community Hospital Median Total Margin



The median total margin at teaching hospitals was 5.3% in FY10, compared with 2.3% for community hospitals. However, community hospitals experienced a greater percent growth (36%) in median profitability between FY09 and FY10.

Teaching hospitals have shown a trend of higher profitability than community hospitals in each of the past eight years.

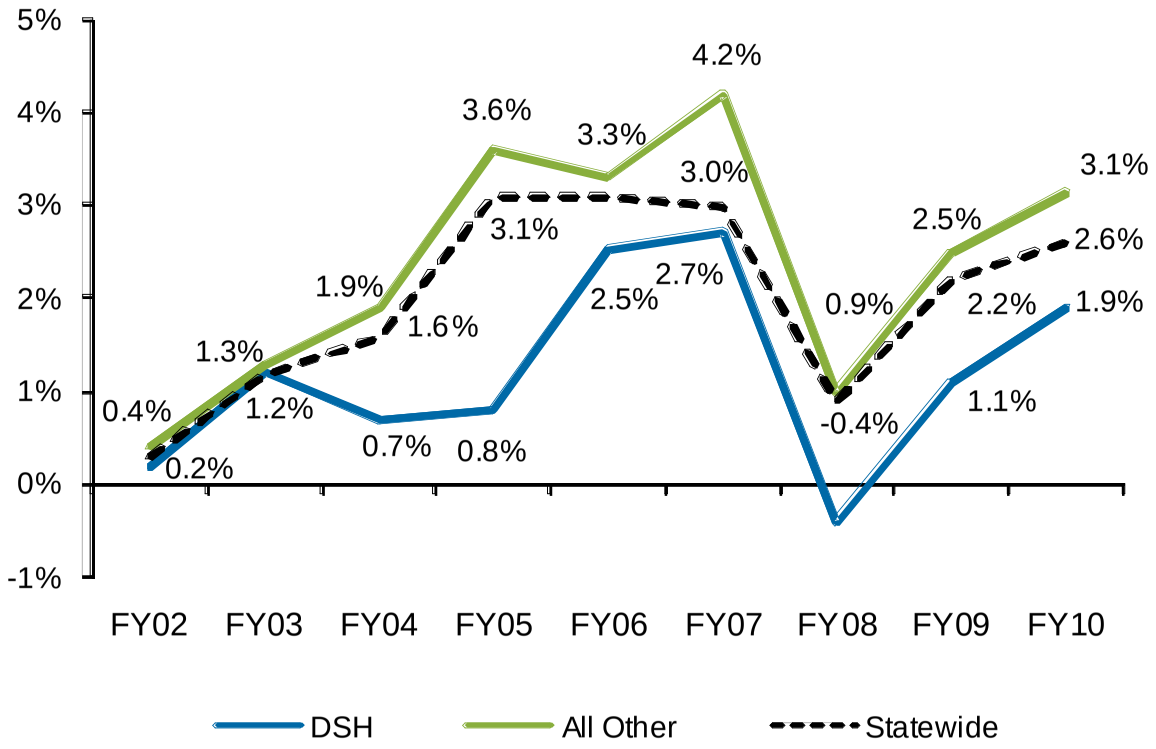
Benchmark: Northeast US median FY08 = 0.9%

Benchmark Source: 2010 Almanac of Hospital Financial and Operating Indicators, INGENIX

Note: Total margin is the ratio of total income to total revenue.

For teaching and community hospital designations please see *Massachusetts Acute Hospital Financial Performance Fiscal Year 2010*, available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/hospital_financial_performance_fy10.pdf (last accessed 7/26/2011).

Disproportionate Share and All Other Hospital Median Total Margin



Note: Total margin is the ratio of total income to total revenue.

Disproportionate share hospitals (DSH) generally have lower profitability than other hospitals.

The median total margin improved at disproportionate share hospitals to 1.9% in FY10 from 1.1% in FY09. The DSH median total margin in FY10 was lower than the median for all other hospitals by 1.2%.

Benchmark: Northeast US median FY08 = 0.9%

Benchmark Source: 2010 Almanac of Hospital Financial and Operating Indicators, INGENIX

For disproportionate share hospital designations please see *Massachusetts Acute Hospital Financial Performance Fiscal Year 2010*, available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/hospital_financial_performance_fy10.pdf (last accessed 7/26/2011).

Acute Hospital FY10 Financial Performance

Hospitals	Operating Margin	Non-Operating Margin	Total Margin	Profit (Loss)
Teaching				
Baystate Medical Center*	6.31%	1.92%	8.23%	$73,830,000
Beth Israel Deaconess Medical Center	4.18%	2.08%	6.25%	$84,212,000
Boston Medical Center*	-3.65%	1.13%	-2.52%	($25,669,000)
Brigham and Women's Hospital	5.00%	0.06%	5.07%	$112,101,000
Cambridge Health Alliance* (FY11,Q1)**	-6.86%	1.24%	-5.63%	($6,956,590)
Children's Hospital Boston	4.38%	1.23%	5.61%	$74,146,000
Dana-Farber Cancer Institute	-4.02%	6.18%	2.16%	$19,166,731
Lahey Clinic	3.21%	2.04%	5.25%	$47,926,331
Massachusetts Eye and Ear Infirmary	-2.63%	1.55%	-1.08%	($2,079,360)
Massachusetts General Hospital	6.13%	0.20%	6.33%	$181,300,000
Mount Auburn Hospital	5.38%	3.35%	8.73%	$27,307,000
Saint Vincent Hospital* (FY11,Q1)**	5.33%	0.00%	5.33%	$4,294,246
Steward St. Elizabeth's Medical Center*	5.61%	0.38%	5.99%	$24,836,005
Tufts Medical Center	0.12%	0.70%	0.82%	$5,285,000
Umass Memorial Medical Center	3.47%	0.61%	4.08%	$57,170820
Community				
Anna Jaques Hospital	2.31%	0.19%	2.51%	$2,766,625
Athol Memorial Hospital*	-3.76%	0.24%	-3.51%	($778,857)
Baystate Franklin Medical Center	-6.07%	0.78%	-5.29%	($4,093,000)
Baystate Mary Lane Hospital	-11.48%	1.77%	-9.71%	($2,860,000)
Berkshire Medical Center*	0.85%	1.77%	2.62%	$8,261,347
Beth Israel Deaconess – Needham	-0.05%	0.46%	0.41%	$218,718
Cape Cod Hospital*	7.16%	-1.42%	5.75%	$22,911,295
Clinton Hospital*	1.57%	1.13%	2.70%	$698,000
Cooley Dickinson Hospital	2.67%	0.71%	3.38%	$5,670,629
Emerson Hospital	-0.70%	0.37%	-0.33%	($605,160)
Fairview Hospital	1.65%	1.30%	2.95%	$1,191,130
Falmouth Hospital*	1.68%	0.33%	2.01%	$2,697,826
Faulkner Hospital	1.51%	-0.45%	1.06%	$1,944,000
Hallmark Health	5.33%	1.68%	7.00%	$19,786,000
Harrington Memorial Hospital	2.53%	1.00%	3.53%	$3,731,300

Hospitals	Operating Margin	Non-Operating Margin	Total Margin	Profit (Loss)
Community				
Health Alliance Hospital	2.41%	0.90%	3.31%	$5,550,435
Heywood Hospital	2.76%	0.95%	3.70%	$3,550,135
Holyoke Medical Center*	-0.01%	0.15%	0.14%	$159,952
Jordan Hospital	2.95%	0.27%	3.22%	$6,349,496
Lawrence General Hospital*	1.11%	0.71%	1.82%	$3,269,000
Lowell General Hospital	3.97%	0.91%	4.88%	$11,615,793
Marlborough Hospital	1.00%	1.99%	2.99%	$2,173,000
Martha's Vineyard Hospital (FY11,Q2)**	5.48%	1.78%	7.26%	$2,173,356
Merrimack Valley Hospital*	-7.38%	0.00%	-7.38%	($4,072,607)
Mercy Medical Center* (FY10,Q3)**	1.26%	-0.31%	0.95%	$1,521,737
MetroWest Medical Center (FY11,Q1)**	-6.63%	0.07%	-6.56%	($4,165,008)
Milford Regional Medical Center	2.75%	0.54%	3.29%	$6,240,237
Milton Hospital	0.95%	0.24%	1.19%	$802,571
Morton Hospital and Medical Center*	1.21%	1.14%	2.35%	$3,123,795
Nantucket Cottage Hospital	-30.10%	7.40%	-22.70%	($6,703,000)
Nashoba Valley Medical Center	-1.79%	0.00%	-1.79%	($807,365)
New England Baptist Hospital	2.31%	1.86%	4.16%	$8,241,000
Newton-Wellesley Hospital	4.90%	0.10%	5.01%	$19,253,000
Noble Hospital*	-3.70%	0.01%	-3.69%	($1,977,562)
North Adams Regional Hospital*	-7.07%	0.66%	-6.41%	($3,964,510)
North Shore Medical Center*	-1.37%	0.15%	-1.22%	($5,197,000)
Northeast Hospital	2.01%	-0.84%	1.16%	$3,710,718
Quincy Medical Center*	-5.63%	-0.10%	-5.72%	($5,928,405)
Saints Medical Center*	-0.32%	0.03%	-0.29%	($413,000)
Signature Healthcare Brockton*	8.31%	0.67%	8.98%	$19,690,096
South Shore Hospital	2.28%	0.00%	2.29%	$9,624,146
Southcoast Hospitals Group*	2.97%	0.88%	3.85%	$24,992,340
Steward Carney Hospital, Inc.*	2.17%	0.02%	2.20%	$2,611,432
Steward Good Samaritan Medical *	5.30%	1.11%	6.41%	$12,726,561
Steward Holy Family Hospital	2.63%	0.51%	3.14%	$4,836,829
Steward Norwood Hospital	1.48%	0.56%	2.04%	$3,448,000
Steward St. Anne's Hospital*	7.06%	1.54%	8.60%	$13,177,346
Sturdy Memorial Hospital	6.84%	4.16%	11.00%	$18,318,598
Winchester Hospital	3.01%	0.11%	3.11%	$8,299,564
Wing Memorial Hospital*	1.13%	0.19%	1.32%	$1,181,000

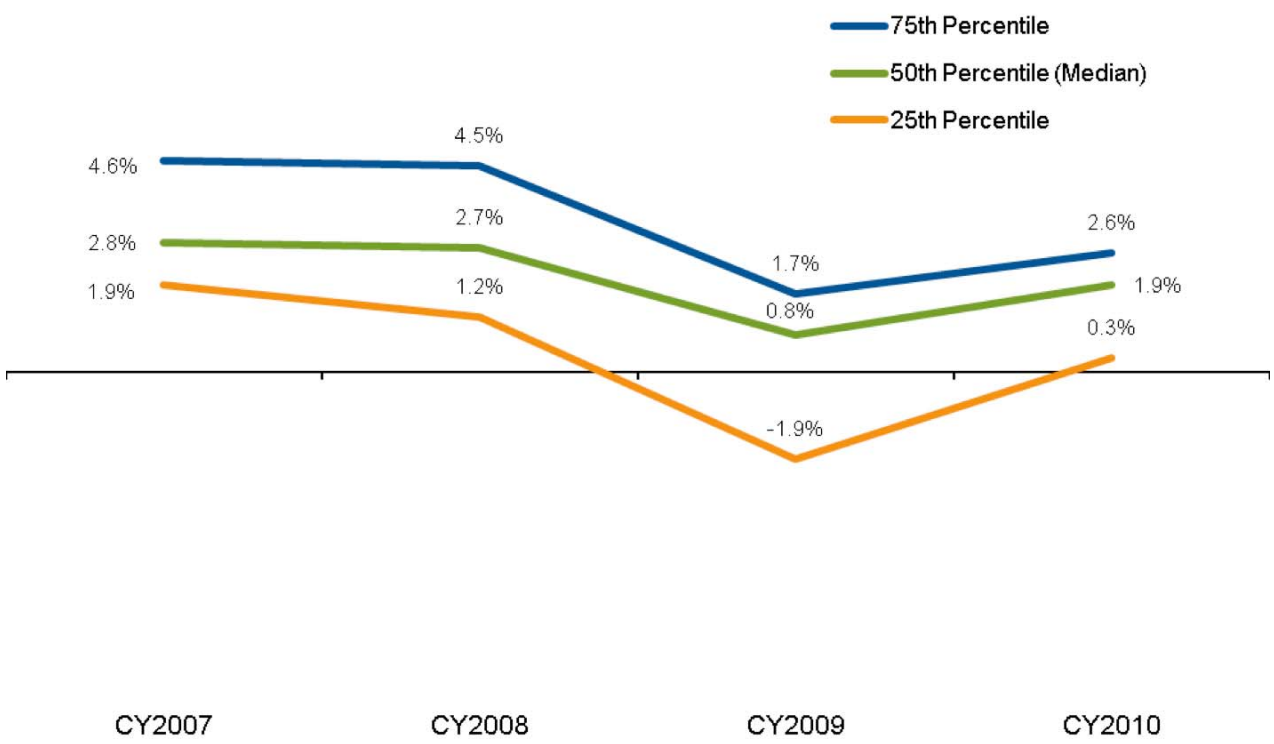
Notes: Profitability percentages may not add due to rounding.
* Denotes Disproportionate Share Hospital.
** Most calculations on this page use data reported by hospitals on an October 1 to September 30 fiscal year. Hospitals noted with two asterisks use alternative fiscal year periods; for these hospitals data reported here is the most current available as of September 30, 2010. Alternative year end FY10 calculations for these hospitals are available on the next slide.

Acute Hospital Financial Performance: Alternative 2010 Fiscal Periods

Hospitals	Reporting Period	Operating Margin	Non-Operating Margin	Total Margin	Profit (Loss)
Cambridge Health Alliance*	7/1/09-6/30/10	-5.21%	1.17%	-4.03%	($20,089,183)
Martha's Vineyard Hospital	4/1/09-3/31/10	0.05%	7.08%	7.13%	$3,900,859
Mercy Medical Center*	1/1/09-12/31/10	3.92%	-0.60%	3.32%	$7,164,168
MetroWest Medical Center	7/1/09-6/30/10	-4.25%	0.14%	-4.11%	($10,606,536)
Saint Vincent Hospital*	7/1/09-6/30/10	8.98%	0.03%	9.01%	$30,416,662

Notes: Profitability percentages may not add due to rounding.
*Denotes Disproportionate Share Hospital.
** Data on this page should be used when comparing fiscal year 2010 to previous fiscal years for these hospitals.

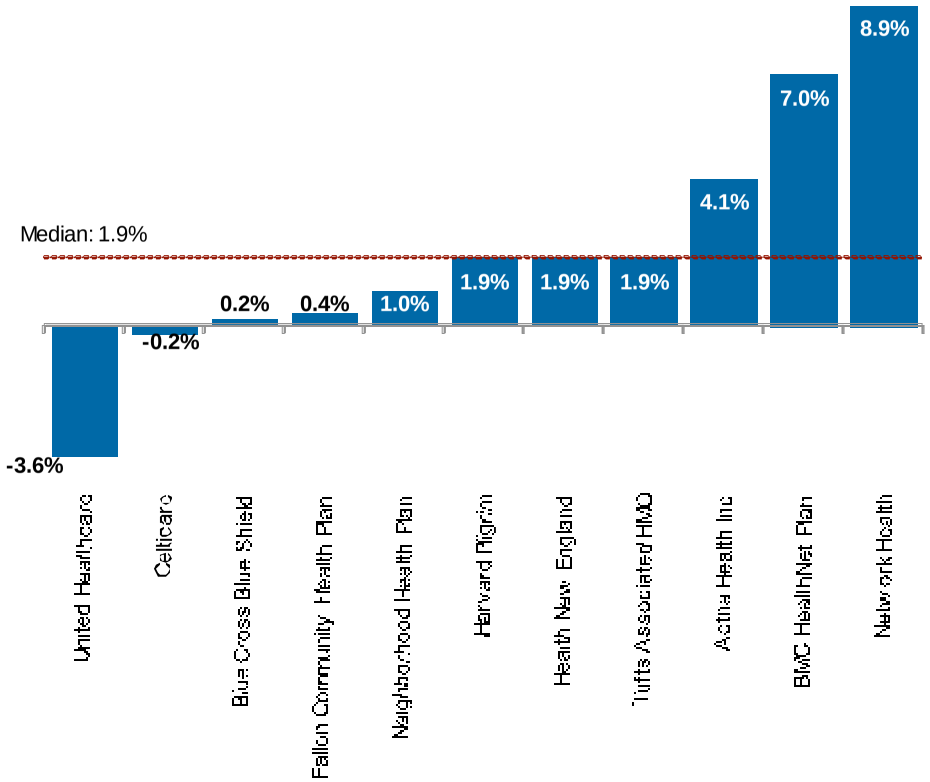
Massachusetts Health Plan Profit Margin Trends, 2007-2010



Between the end of the 2009 and 2010 calendar years, Massachusetts health plan profit margins generally rose, although overall, 2010 margins remain below margins report for the 2007 calendar year.

Information is self-reported by plans to the Massachusetts Division of Insurance (DOI) and represents both in-state and out-of-state business in private insurance products, Medicare, MassHealth, and Commonwealth Care. Information is limited to the following health maintenance organizations (HMOs) licensed with DOI or under contract with MassHealth: Aetna Health Inc, Blue Cross Blue Shield of Massachusetts (including HMO Blue), BMC HealthNet Plan, CeltiCare Health Plan of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Network Health, Tufts Associated HMO, and United Health Care of New England. HMOs registered with DOI but with less than 10,000 covered lives are excluded from this analysis as financial information for these companies is more volatile. CeltiCare financial information is excluded for periods prior to the end of calendar year 2010.

Massachusetts Health Plan CY10 Profit Margins



Profit margins for Massachusetts health plans ranged from a low of -3.6% to a high of 8.9% during the 2010 calendar year.

Information is self-reported by plans to the Massachusetts Division of Insurance (DOI) and represents both in-state and out-of-state business in private insurance products, Medicare, MassHealth, and Commonwealth Care. Information is limited to the following health maintenance organizations (HMOs) licensed with DOI or under contract with MassHealth: Aetna Health Inc, Blue Cross Blue Shield of Massachusetts (including HMO Blue), BMC HealthNet Plan, CeltiCare Health Plan of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Network Health, Tufts Associated HMO, and United Health Care of New England. HMOs registered with DOI but with less than 10,000 covered lives are excluded from this analysis as financial information for these companies is more volatile.

Massachusetts Health Plan CY10 Financial Performance

	Profit Margin	Profit (Loss)
Aetna Health Inc.	4.1%	$ 161,653,734*
Blue Cross Blue Shield of Massachusetts and HMO Blue	0.2%	$ 13,388,970
BMC HealthNet Plan	6.6%	$ 81,247,846
Celticare Health Plan of Massachusetts	-0.2%	$ (122,199)
Fallon Community Health Plan, Inc.	0.4%	$ 4,092,619
Harvard Pilgrim Health Care, Inc.	1.9%	$ 44,248,130
Health New England, Inc.	1.9%	$ 7,342,633
Neighborhood Health Plan, Inc.	1.0%	$ 10,705,389
Network Health	8.9%	$ 51,397,101
Tufts Associated Health Maintenance Organization	1.9%	$ 44,455,181
United Healthcare of New England, Inc.	-3.6%	$ (14,928,392)

*Aetna's financial reporting is for the entire corporation, not simply Massachusetts business.
Source: DOI annual financial statements.

Potential price saving scenarios by narrowing price variation for selected DRGs

- The following simulations of reduced price variation were conducted to understand the potential impact on hospital inpatient health care spending.
  - Payments were paid at the 2009 median price;
  - All payments above the existing 80th percentile were instead made at the 80th percentile;
  - The range of payments were narrowed to the existing 20th percentile and 80th percentile; and
  - Payments below the existing 20th percentile were instead made at the 20th percentile.
- Across all of the selected DRGs, the greatest impact on total payments would occur if private payer prices above the 80th percentile were instead made at the 80th percentile within each severity category. This model would have reduced total inpatient payments by 5%, or $170 million when extrapolated to total inpatient spending.
- If the highest payments were made at the 80th percentile of prices but the lowest payments were made at the 20th percentile, more than $88 million in estimated savings would result.
- Alternatively, if the lower end of payments were increased to the 20th percentile without a corresponding decrease in upper end payments, the result would be an overall increase of 2.4% or $80 million.

Potential price saving scenarios by narrowing price variation for selected DRGs

APR-DRG	All payments made at the median	All payments above the 80th percentile reduced to the 80th percentile	All payments made between the 20th and 80th percentile	Payments below the 20th percentile increased to the 20th percentile
Total, all selected DRGs	-3.3%	-5.0%	-2.6%	2.4%
Laparascopic cholecystectomy	-2.1%	-4.7%	-1.1%	3.6%
Procedures for obesity	1.2%	-3.2%	-0.7%	2.4%
Uterine and adnexa procedures for nonmalignancy except leiomyoma	-0.8%	-3.8%	-1.1%	2.7%
Appendectomy	-3.1%	-5.9%	-2.1%	3.7%
Knee joint replacement	-2.1%	-5.1%	-3.1%	2.1%
Intervertebral disc excision and decompression	-2.7%	-5.8%	-2.7%	3.1%
Knee and lower leg procedures	-2.9%	-4.6%	-1.7%	3.0%
Hip joint replacement	1.1%	-4.5%	-2.5%	2.0%
Chronic obstructive pulmonary disease	-8.0%	-7.1%	-4.9%	2.2%
Pneumonia	-6.1%	-7.9%	-5.2%	2.8%
Acute myocardial infarction	-12.1%	-10.9%	-8.3%	2.6%
Congestive heart failure	-7.9%	-9.3%	-5.6%	3.7%
Cesarean delivery	-5.0%	-4.5%	-2.5%	2.0%
Vaginal delivery	-4.9%	-4.2%	-2.1%	2.1%

Potential price saving scenarios by narrowing price variation for selected physician services

- The following simulations of reduced price variation were conducted to understand the potential impact on physician health care spending.
  - Payments were paid at the 2009 median price;
  - All payments above the existing 80th percentile were instead made at the 80th percentile;
  - The range of payments were narrowed to the existing 20th percentile and 80th percentile; and
  - Payments below the existing 20th percentile were instead made at the 20th percentile.
- Modeling all private payer prices for professional services at the median payment would have the greatest impact on payments, reducing spending for the selected CPT codes collectively by about 10% or an estimated $640 million in total.
- Narrowing the range in price variation between the 20th and 80th percentiles (by increasing the lowest prices and reducing the highest prices) would reduce total payments by almost 3%, an estimated $179 million in total savings.
- Alternatively, if the lower-end of payments were increased to the 20th percentile without a corresponding decrease in upper-end payments, the impact would be an increase of 2.2% or $138 million.

Potential price saving scenarios by narrowing price variation for selected physician services

Service type and CPT Code	All payments made at the median	All payments above the 80th percentile reduced to the 80th percentile	All payments made between the 20th and 80th percentile	Payments below the 20th percentile increased to the 20th percentile
Total, all selected services	-10.4%	-5.0%	-2.8%	2.2%
Office/outpatient visit, established patient, low complexity	-11.4%	-5.0%	-2.4%	2.6%
Office/outpatient visit, established patient, moderate complexity	-10.3%	-3.4%	-0.7%	2.7%
Office-based psychotherapy visit	-9.7%	-6.5%	-5.9%	0.6%
Office-based psychotherapy visit, with medical evaluation and management services	-8.8%	-6.9%	-3.9%	3.1%
Therapeutic exercises	-21.2%	-11.8%	-11.5%	0.3%
Chiropractic manipulation treatment, spinal, 1-2 regions	1.0%	-0.5%	1.0%	1.6%
MRI brain without and with contrast	-7.5%	-4.6%	-3.2%	1.4%
Radiologic examination, chest-frontal and lateral views	-13.2%	-6.8%	-5.0%	1.8%
Routine maternity care including vaginal delivery	-10.8%	-1.8%	0.6%	2.4%
Arthroscopic partial or total resection of medial or lateral meniscus	-11.2%	-3.9%	-1.5%	2.4%

Potential Strategies to Reduce Disparities in Payment Rates

Potential Strategies

- Price Transparency
- Market Power Intervention
- Consumer Incentives
- Benchmarks for Variation
- Acceptable Factors for Variation
- Price or Price Growth Thresholds
- Reference Pricing
- Rate Setting

Price Transparency

- **Definition:** Requires the disclosure of prices in a manner that enables the consumer to make more informed care decisions.

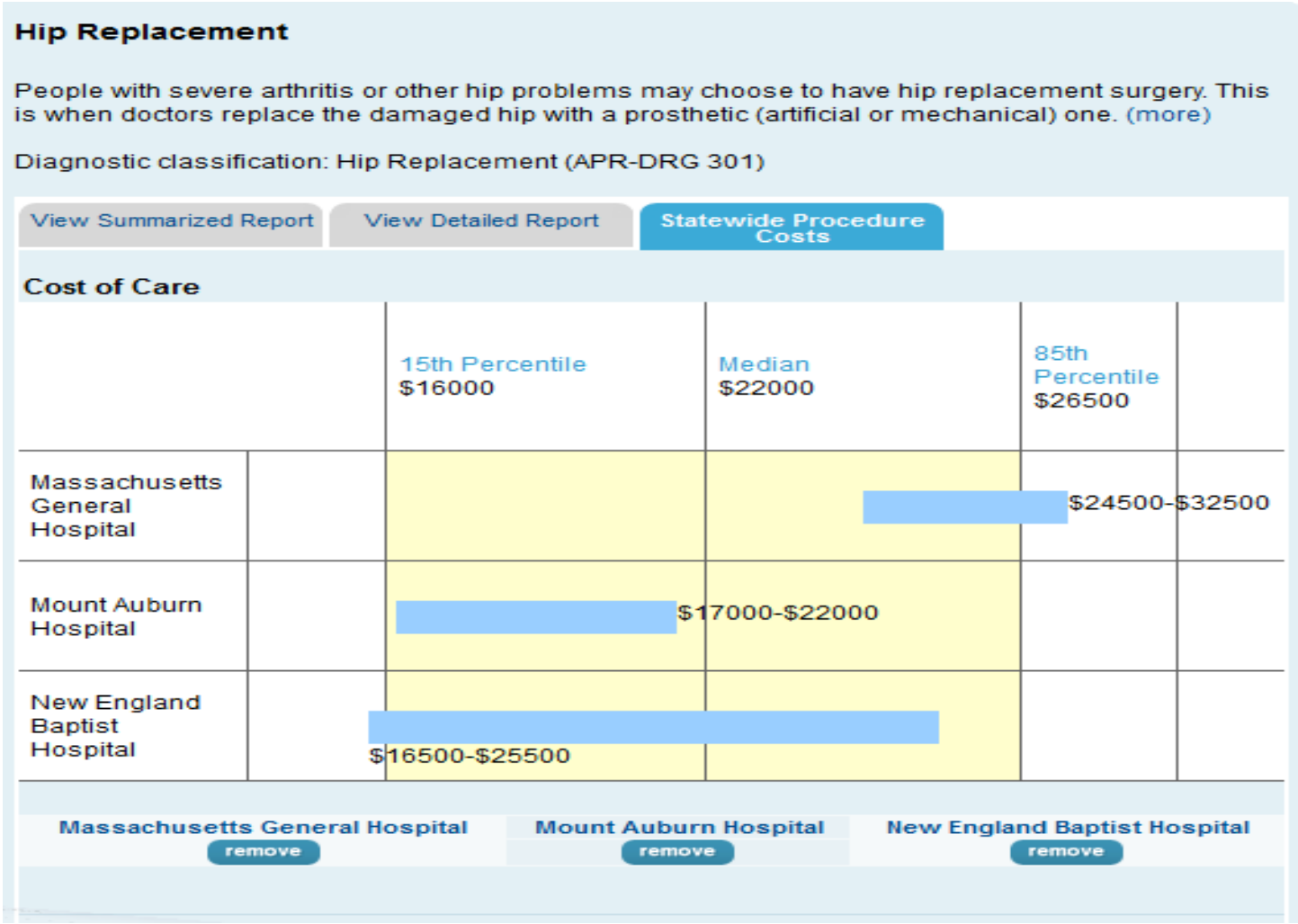
Price Transparency

Current Implementation

- About 30 states, including Massachusetts, have already implemented or taken steps to implement transparency initiatives.
- *Massachusetts:*
  - The Health Care Quality and Cost Council provides consumers with *MyHealthCareOptions*, a website that allows the user to search and compare the price and quality of providers relative to each other and to a statewide average. The results do not indicate price based on a specific payer. User traffic totals about 75 visitors per day and each visitor spends slightly over two minutes on the website.
  - Chapter 305 of the Acts of 2008 requires the Division of Health Care Finance and Policy to hold annual hearings concerning health care provider and payer costs and cost trends.
  - Chapter 288 of the Acts of 2010 contained a number of initiatives intended to improve transparency including the requirement that the Division of Health Care Finance and Policy collect total medical expense (TME) and relative price data and that health plans post such data publicly.

Price Transparency

Current Implementation: View of *MyHealthCareOptions* website



Price Transparency

Current Implementation

- *New Hampshire: NH Health Cost* is a website for consumers to gather information on the price of health services and estimate their out-of-pocket costs. Unlike *MyHealthCareOptions*, New Hampshire's website displays price information for common procedures by payer and insurance product, allowing consumers to see the variation in prices paid to providers.

- *California:* California's Office of Statewide Health Planning and Development publishes the median charges and average length of stay for common scheduled elective inpatient procedures. The website allows the user to easily compare the amount a hospital charges for the selected procedures, although it does not indicate how much the provider was actually paid.

Price Transparency

Current Implementation: View of *NH Health Cost* website

Detailed estimates for Tonsillectomy with Adenoidectomy (outpatient)

Procedure: Tonsillectomy with Adenoidectomy (outpatient)
Insurance Plan: Anthem - NH, Preferred Provider Organization (PPO)
Within: 1000 miles of 03031
Deductible and Coinsurance Amount: $2,000.00 / 0%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
ELLIOT ONE-DAY SURGERY CENTER	$2000	$126	$2126	LOW	HIGH	ELLIOT ONE-DAY SURGERY CENTER 603.663.5900
BEDFORD AMBULATORY SURGICAL C	$2000	$537	$2537	HIGH	MEDIUM	BEDFORD AMBULATORY SURGICAL C 603.622.3670
CONCORD AMBULATORY SURGERY CENTER	$2000	$680	$2680	LOW	MEDIUM	
THE SURGICENTER AT ST JOSEPH	$2000	$794	$2794	LOW	MEDIUM	THE SURGICENTER AT ST JOSEPH 603.882.3000
MARY HITCHCOCK MEMORIAL HOSPITAL	$2000	$2093	$4093	LOW	VERY HIGH	MARY HITCHCOCK MEMORIAL HOSPITAL 603.650.5000
LITTLETON REGIONAL HOSPITAL	$2000	$2999	$4999	HIGH	MEDIUM	LITTLETON REGIONAL HOSPITAL 603.444.9000
NEW LONDON HOSPITAL	$2000	$3307	$5307	HIGH	VERY LOW	NEW LONDON HOSPITAL 603.526.2911
SOUTHERN NH MEDICAL CENTER	$2000	$3569	$5569	LOW	MEDIUM	SOUTHERN NH MEDICAL CENTER 603.577.2000
ELLIOT HOSPITAL	$2000	$4487	$6487	LOW	VERY HIGH	ELLIOT HOSPITAL 603.669.5300

Price Transparency

Evidence of Effectiveness

- There has been little research on whether publishing prices reduces price variation in any given market. In New Hampshire, one study found that price variation for medical procedures had not decreased two years after the launch of *NH Health Cost* and speculated that the persistence of variation may be due to weak provider competition within the state.

- In California, researchers found negligible change in price variation following the implementation of the transparency website. Researchers postulated that the lack of variation reduction may have been due to patients weighting quality more than price. Researchers also observed that many patients did not have the financial incentive, in the form of premiums or deductibles, to use the information.

Tu, HA and Lauer, JR. Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience. Center for Studying Health System Change No. 128, November 2009.
"January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)" AHIP Center for Policy and Research. June 2011. www.ahipresearch.org/pdfs/hsa2011.pdf.
Austin, D.A. and Jane Gravelle. "Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector." *Congressional Research Service* April 2008.

Market Power Intervention

- **Definition:** Mitigates the competitive advantage of large provider systems.

Market Power Intervention

Implementation Options

- *Regulation of contracting practices:* Regulation of provider negotiating and contracting practices could address:
  - Contract provisions that require payers to contract with all providers within a system, rather than contracting only with the individual provider facilities that a health plan may need to ensure adequate network access.
  - Contract provisions that require payers to pay the same or similar prices to all providers within a system.
- *Antitrust scrutiny:* Another approach could be closer anti-trust scrutiny by federal and state governments tasked with monitoring and regulating potentially anti-competitive behavior (Federal Trade Commission, Massachusetts Attorney General). Mechanisms for anti-trust scrutiny already exist, and could be applied more aggressively than has been historical practice.
- *Legislation:* Legislation could limit future market consolidation.

Market Power Intervention

Current Implementation Massachusetts

- Chapter 288 of the Acts of 2010 prohibits providers from utilizing system affiliations to achieve a guaranteed right of participation in a tiered or select network plan; uniform placement in the same tier of a tiered network plan; or all or nothing inclusion in a select network plan.

Market Power Intervention

Current Implementation

- A March 2011 report from the Federal Trade Commission (FTC) details a number of FTC actions taken in the health care sector. These include:
  - A 2010 hospital merger in Ohio was delayed by the FTC because of a preliminary finding that the merger would "reduce competition and allow [the company] to raise prices for general acute-care and inpatient obstetrical services." While the merger was completed before the complaint was filed with the FTC, the FTC ordered the merged hospitals to operate and negotiate as separate entities pending a final determination.
  - In 2008, the Virginia Attorney General joined with the FTC in securing an injunction against the merger of a hospital into a larger hospital system in the state. In its complaint, the FTC noted that the merged hospital system would control 73% of the licensed hospital beds in Northern Virginia.
  - In 2007, the FTC found that, after a merger of three Illinois hospitals, the result was "price increases for all three hospitals that were significantly higher than price increases for other comparable hospitals, forcing payers to accept the increases or lose the three hospitals from their networks." The FTC ordered the three hospitals to negotiate and contract separately from one another.

U.S Federal Trade Commission, Health Care Division, "Overview of FTC Antitrust Actions in Health Services and Products," March 2011, www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf.

Market Power Intervention

Evidence of Effectiveness

- Although there were approximately 89 hospital mergers and acquisitions in 2010 involving 227 hospitals, the aforementioned FTC report details only one antitrust action for general acute care hospitals during 2010.

Galloro, V. "Picking Up Speed," *Modern Healthcare*; 41(3):22-26, 28-31, Jan. 17, 2010.

Consumer Incentives

- **Definition:** Incentivize patient choice for cost-effective providers. This strategy is sometimes referred to as "value-based benefit design" or "value-based insurance design."

Consumer Incentives

Implementation Options

- Payers could continue to develop tiered and/or select network plans with reduced premiums or reduced cost-sharing.
- The Massachusetts Legislature has already mandated that health plans offer products that employ health benefit designs to engage patients more fully in choosing lower-cost providers. Additional actions could include:
  - Increasing required premium differentials between traditional network benefit programs and tiered/select network programs.
  - Specifying cost-sharing differentials between providers in and out of select network products and between tiered network products.
  - Limiting the ability of providers to opt out of tiered network products.
  - Specification of criteria that insurers must use to determine providers' eligibility for the select network.

Consumer Incentives

Current Implementation

- The Group Insurance Commission has offered tiered and select network products for several years. Currently, 31% of state employees, up from 19%, opted into tiered and select network products following the announcement of a three month premium holiday for individuals in those products.
- Section 32 of Chapter 288 of the Acts of 2010 requires carriers that cover more than 5,000 eligible individuals or small employers to offer a select or tiered network product to eligible individuals and small employers in the largest metropolitan region in the carrier's service area that costs at least 12% less than the carrier's most actuarially similar non-select/non-tiered network product.
  - Blue Cross Blue Shield reports significant enrollment growth since introducing its product in early 2011.
  - Other commercial insurers report notable employer interest in products introduced July 1, 2011.

AON Hewitt, "2011 Health Care Survey," http://img.en25.com/Web/AON/Health_Care_Survey_2011_060911.pdf.
Syre S, "Uncertain Diagnosis," *Boston Globe*, June 21, 2011.

Consumer Incentives

Evidence of Effectiveness

- Savings associated with the Group Insurance Commission's increased enrollment in tiered and select network products are estimated to be $30 million over the next year.
- A recent report by a health plan to the Institute of Medicine detailed significant savings from tiered networks, though it is not clear whether the savings were due to lower prices or shifting utilization to lower cost providers.
- Several Massachusetts hospitals have reported use of select networks for their self-insured health insurance plans for hospital employees, and have attested to significant financial benefit.

Thomas JW, Nalli GA and Coburn AF, " What We Know and Do Not Know About Tiered Provider Networks," *Journal of Health Care Finance*, 33(4), June 1, 2007
Carrara L, " Tiered Provider Networks Impact on Value-Based Benefit Design," presentation to Institute of Medicine, July 2009, www.iom.edu/~/media/Files/Activity%20Files/Quality/VSRT/22-Tiered%20Provider%20Networks%20Impact%20on%20Value-Based%20Benefit%20Design.pdf.

Consumer Incentives

Evidence of Effectiveness

- There is strong anecdotal evidence that providers do take notice of benefit plan designs that provide incentives for patients to choose certain providers, and that such products have an impact on providers.
  - After the Maine state employee benefits plan adopted a co-pay differential that favored hospitals reporting quality data to the Leapfrog Group, 100 percent of hospitals began reporting such data.
  - The Buyers Health Care Action Group in Minnesota reported that the use of differential employee health insurance contributions based on provider cost and quality led providers to approach the group to better their standing.

Thomas JW, Nalli GA and Coburn AF, " What We Know and Do Not Know About Tiered Provider Networks," *Journal of Health Care Finance*, 33(4), June 1, 2007
Carrara L, " Tiered Provider Networks Impact on Value-Based Benefit Design," presentation to Institute of Medicine, July 2009, www.iom.edu/~/media/Files/Activity%20Files/Quality/VSRT/22-Tiered%20Provider%20Networks%20Impact%20on%20Value-Based%20Benefit%20Design.pdf.

Benchmarks for Variation

- **Definition:** Limits the amount of variation that an individual payer permits for a given service or market basket of services across the payer's network.

Benchmarks for Variation

Implementation Options

- Permissible price variation could be defined in terms of the percentage variation from high to low or around a baseline within a payer's network. Individual providers and payers could negotiate within the pre-defined limits.

- Contracts and payment practices could be monitored to ensure compliance.

Benchmarks for Variation

Current Implementation / Evidence of Effectiveness

- Limits on price variation are not currently in place in any state.
- This strategy has not been evaluated.

Acceptable Factors for Variation

- **Definition:** Specifies the components for which variation is acceptable and could define the extent of component variation. This method could prohibit variation in price due to any other reason.

Acceptable Factors for Variation

Implementation Options

- Factors could be determined as acceptable sources of price variation. There are at least two possible implementation and enforcement mechanisms:
  - Insurers and providers may negotiate prices and determine specific application of factors without oversight, but maintain the ability for the state to review contracts and request justification for provider price variations. Such justification would have to be based on the acceptable factors, if not, the contract would need to be re-negotiated.
  - Determine the range of variation allowed for each factor. Provider contracts could be reviewed to ensure that provider price variation falls within acceptable limits. Permissible variation could be determined at the individual provider level, or broadly for all providers within a certain category.

Acceptable Factors for Variation

Current Implementation / Evidence of Effectiveness

- Medicare's Inpatient Prospective Payment System uses a base DRG rate and then adjusts for specific factors.
  - The base rate reflects the national average inpatient cost per discharge from a prior period, trended forward to the rate period using annual update factors
  - Specific adjustment factors include:
    - geographic adjustments including wage area and capital factors
    - DRG weights to reflect case intensity
    - medical education
    - disproportionate share status
    - high cost outlier (case specific)
- DHCFP 2011 health care cost trends analysis found that the variation associated with these factors results in a range in Medicare prices that is similar in breadth to variation in private payer prices. However, it results in a different ranking of hospital prices. Unlike private payer variation, variation in Medicare prices is completely transparent and subject to public scrutiny.

Price or Price Growth Thresholds

- **Definition:** Establishes a ceiling on the allowable price for any given service or aggregation of services, or sets an allowable threshold for price increases.

Price or Price Growth Thresholds

Implementation Options

- *Price threshold:* There could be a threshold set on unit prices, bundled payments, global payments, or a price for a market-basket of services. Price threshold could be imposed on all services for all providers. Existing market prices could be used as a baseline and limit future growth to a specified amount.

- *Price growth threshold:* There could be a threshold set on the rate of price growth for some or all providers. Thresholds could vary depending upon a provider's relative price or apply only to providers with the highest relative prices. A sliding scale approach could be used whereby the highest priced providers are permitted to grow at a slower rate than the lowest priced providers.

Price or Price Growth Thresholds

Current Implementation / Evidence of Effectiveness

- Price or price growth thresholds do not appear to be in place in any state.

- Chapter 495 of the Acts of 1991 included hospital charge thresholds for two years as a small component of the deregulation of acute hospitals in Massachusetts. The impact of this strategy has not been independently evaluated.

Reference Pricing

- **Definition:** Price for a given health product or service is based on an established, published external source. All providers or all insurers could be required to charge or pay the benchmark price or within a percentage threshold of the benchmark price.

Reference Pricing

Implementation Options

- Implementation can apply to a broad range of health services or be targeted just towards those services with strong evidence of clinical equivalence across providers. The focus could be on high cost or high volume services.
- Reference benchmarks could be obtained from a variety of sources including Medicare or existing market data.
- Reference pricing could include acceptable ranges of variation from the external source to be set through negotiation.

Reference Pricing

Current Implementation

- No state currently imposes limits on price variation from these reference points.

- Reference pricing for health services has been used in other countries including: Germany (1989); Netherlands (1991); Sweden (1993); Denmark (1993); New Zealand (1993); Australia (1996); Italy (1996); and Spain (2000).

Reference Pricing

Evidence of Effectiveness

- The RAND Corporation modeled a scenario in which academic medical centers were subject to reference pricing and consumer purchasing engagement. Payment would be based on community hospital rates and consumers may opt to pay the difference for care at an academic medical center. This model assumed a phased implementation.
  - Under the upper bound scenario, 97% of DRGs were subject to reference pricing. The model concluded that reference pricing could save up to $8.6 billion (1.3%) between 2010 and 2020. Savings to private insurers could total as much as $8.8 billion. However, consumers would spend an additional $2.9 billion as a result of increased co-payments for services at academic medical centers.
  - Under a more conservative model in which only maternity services were subject to reference pricing, total savings over ten years were only $526 million. Maternity service account for approximately 15% of hospital discharges.

	Lower Bound Model			Upper Bound Model		
	2010	**2010-2015**	**2010-2020**	**2010**	**2010-2015**	**2010-2020**
Status Quo	$43.2b	$306.6b	$669.6b	$43.2b	$306.6b	$669.6b
Total Savings	-$11m	-$159m	-$526m	-$182m	-$2.6b	-$8.6b
% Savings	-0.03%	-0.05%	-0.08%	-0.42%	-0.85%	-1.28%

Controlling Health Care Spending in Massachusetts: An Analysis of Options, The RAND Corporation, August 2009. Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf (last accessed 7/26/2011).

Rate Setting

- **Definition:** Establish a schedule of health care service prices that must be charged by providers or paid by payers.

Rate Setting

Implementation Options

- Rate setting has typically been applied to inpatient services only, but rates could be set for all services which are subject to negotiation.
- Rate setting methodology could be based on the methodology of other payers. The Medicare inpatient prospective payment system (IPPS) pays most acute hospitals in the nation a fixed base amount with additional payments in the form of factors that adjust for regional differences in costs and patient severity. It could also be set on a per-diem basis, unit cost, or global payment level. It could account for factors that contribute to cost, quality, or outcomes.

Rate Setting

Current Implementation

- Rate setting was a popular strategy to control costs in the 1970s with 30 states adopting some form of rate setting. Rate setting fell out of favor in the 1980s and hospitals rates were deregulated in many states during the rise of the managed care. Five states, including Massachusetts, had substantial experience with rate setting. Today, Maryland and West Virginia are the only states which continue to set hospital rates.

- *Massachusetts:* Massachusetts set hospital rates for the 16-year period between 1975 and 1991 through an independent commission. The Commission set per-diem rates for Medicaid and established controls for hospital charges. In Massachusetts, rate setting ended after a period of unlimited discounting authority was given to HMOs to encourage their growth in the marketplace.

Atkinson, G. "State Hospital Rate-Setting Revisited." The Commonwealth Fund pub.1332, Vol. 69. October 2009.
McDonough, J. "Tracking the Demise of State Hospital Rate Setting." *Health Affairs,* 16, No.1 (1997):142-149.

Rate Setting

Current Implementation

- *Maryland:* Maryland has a long history with hospital rate setting. In 1974, commercial payer rates were established for hospitals and in 1977 federal waivers were obtained to apply the same rates to Medicare and Medicaid payments. Maryland's rate setting involves a service-specific rate (e.g., ICU per diems) and accounts for cost and a margin for profitability. Hospital revenue is controlled through imposing per-encounter limits though hospital revenue is later adjusted based on performance. This dual approach aligns the motivation of both payers and providers into controlling utilization. Maryland's rate system also receives periodic adjustment for inflation and has uncompensated care built into all payers' rates equally.

- *West Virginia*: West Virginia has been regulating hospital prices since 1985 by setting revenue limits for commercial payers and implementing price growth thresholds on rate increases. West Virginia sets rates by calculating the average charge for commercial payers by analyzing prior year's hospital expense, revenue, and utilization data.

Murray, R. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs*, 28, no.5 (2009): 1395-1405.
West Virginia Hospital Association "Hospital Rate Setting and Financial Disclosure."

Rate Setting

Evidence of Effectiveness

- During the period of rate setting in Massachusetts, hospital costs were nearly 2 percent below national rates, but after 1991 costs increased at the same rate as the nation. Price variation existed in Massachusetts during the time period of rate setting as HMOs were not subject to rate setting and were allowed to negotiate lower prices.

- Rate setting in Maryland has been successful in controlling price variation as well as cost growth. The cost of a hospital admission in Maryland fell from 26 percent above the national average in 1975 to 2 percent below the national average in 2007. One researcher calculated that if costs had risen at the same rate as the nation, health care costs in Maryland would have been $40 billion more. On the other hand, if the national average cost slowed to match that of Maryland's, health care costs would have decreased by $1.8 trillion. West Virginia has also experienced a similar control of cost growth.

Murray, R. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs*, 28, no.5 (2009): 1395-1405.
Atkinson, G. "State Hospital Rate-Setting Revisited." The Commonwealth Fund pub.1332, Vol. 69. October 2009.

Rate Setting

Evidence of Effectiveness

- The RAND Corporation modeled a scenario which implemented rate regulation for routine community care at academic medical centers and highly reimbursed community hospitals. The model limited payment for non-tertiary care to the average community hospital rate.
  - The model concluded that non-tertiary rate regulation could save as much as $18 billion, or a 2.7% decline in spending, over ten years. This assumed that 97% of DRGs were covered by rate regulation.
  - Under a more conservative model, assuming only maternity services were subject to rate regulation, ten year savings would be $1.4 billion, or 0.2% of total spending. Maternity service account for approximately 15% of hospital discharges.

	Lower Bound Model			Upper Bound Model		
	2010	**2010-2015**	**2010-2020**	**2010**	**2010-2015**	**2010-2020**
Status Quo	$43.2b	$306.6b	$669.6b	$43.2b	$306.6b	$669.6b
Total Savings	-$93m	-$641m	-$1.4b	-$1.2b	-$8.4b	-$17.9b
% Savings	-0.21%	-0.21%	-0.20%	-2.82%	-2.74%	-2.67%

Controlling Health Care Spending in Massachusetts: An Analysis of Options, The RAND Corporation, August 2009. Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf (last accessed 7/26/2011).

Recent Proposals to Address Price Variation

Recent Proposals to Address Price Variation

An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments

The Governor outlines several strategies that may address variation in provider prices, including:

- Requiring the Division of Health Care Finance and Policy to promote transparency through the dissemination of data regarding pricing, purchasing, and contracting for ACOs.
- Requiring the Division of Health Care Finance and Policy to establish and support alternative payment methodologies containing appropriate factors for adjustment including medical education, stand-by services and emergency services, services provided by disproportionate share hospitals, care coordination and community based services, and the use and advancement of medical technology and pharmacology.
- Requiring the Attorney General to monitor consolidation, payer contracting trends, and other market effects and take appropriate action to prevent excess consolidation or collusion of providers.

Recent Proposals to Address Price Variation

An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments

- Allowing the Commissioner of Insurance to require carriers to follow certain annual parameters in reimbursement contracts with providers based on:
  - Growth in economic indicators;
  - Rate of increase of total medical expenses;
  - Rate of reimbursement relative to carrier's network average;
  - Transition to alternative payment methodologies; and
  - Additional factors at the Commissioner's discretion.
- Allowing the Commissioner of Insurance to disapprove carrier rate filings that are based on provider rates of reimbursement that are not consistent with the annually established parameters.
- Disallowing contract provisions that require carriers to contract with affiliated entities.

Recent Proposals to Reduce Price Variation

Ellen Zane

- In written testimony for DHCFP's annual cost trends hearings, Ellen Zane stated "A uniform base payment format, such as a single base fee schedule, claims submission format, and payment policy and procedures across all payers will help drive balance and transparency in the market." With the base rates set, payers and providers could then negotiate inflators that would take into account factors like teaching costs or be adjusted for the severity of illness of patients.

Tufts Medical Center pre-file Cost Trends testimony. Exhibit B. Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/written_testimony/TuftsAHMO_Exhibit_B.pdf (last accessed 7/15/11).
Goldberg, Carey. "Tufts Medical Center CEO: Give Us a Uniform Rulebook, No More 'Bags of Cash.'" *Wbur.org.* July 5, 2011.

Recent Proposals to Reduce Price Variation

Massachusetts Association of Health Plans

- In its proposal to reduce payment disparities caused by market power, the Massachusetts Association of Health Plans suggests a plan including the following elements:
  - Implement a limit on rates to outlier providers who are not willing to negotiate affordable alternative payment methods for 2011-2015.
  - Each plan identifies its own high-cost, outlier providers based on relative pricing information submitted to DHCFP.
  - Providers above a certain percentage of a health plan's median reimbursement rate would be deemed outliers.
  - A default FFS rate would apply at the expiration of the current contract if the provider and health plan cannot negotiate affordable alternative payment arrangements.
  - The default rate would continue in effect until 2015, or until such time as the Outlier Provider and health plan voluntarily enter into an affordable global payment agreement.

Next Steps: Meeting 4

- Stakeholder outreach
- Discussion of strategies to reduce price variation

Special Commission on Provider Price Reform

August 15, 2011

Agenda

- Welcome
- Review of Revised Principles for Provider Price Reform
- Discussion of Potential Strategies to Reduce Disparities in Payment Rates
- Next Steps

Revised Principles for Provider Price Reform

- The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.
- Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.
- Provider prices may vary.
- Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.
- When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.
- Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.
- Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.
- Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
- Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.

Potential Strategies

- Price Transparency
- Market Power Intervention
- Consumer Incentives
- Benchmarks for Variation
- Acceptable Factors for Variation
- Price or Price Growth Thresholds
- Reference Pricing
- Rate Setting

Price Transparency

- **Definition:** Requires the disclosure of prices in a manner that enables the consumer to make more informed care decisions.

Market Power Intervention

- **Definition:** Mitigates the competitive advantage of large provider systems.

Market Power Intervention

Implementation Options

- *Regulation of contracting practices:* Regulation of provider negotiating and contracting practices could address:
  - Contract provisions that require payers to contract with all providers within a system, rather than contracting only with the individual provider facilities that a health plan may need to ensure adequate network access.
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  - Determine the range of variation allowed for each factor. Provider contracts could be reviewed to ensure that provider price variation falls within acceptable limits. Permissible variation could be determined at the individual provider level, or broadly for all providers within a certain category.

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Implementation Options

- *Price threshold:* There could be a threshold set on unit prices, bundled payments, global payments, or a price for a market-basket of services. Price threshold could be imposed on all services for all providers. Existing market prices could be used as a baseline and limit future growth to a specified amount.

- *Price growth threshold:* There could be a threshold set on the rate of price growth for some or all providers. Thresholds could vary depending upon a provider's relative price or apply only to providers with the highest relative prices. A sliding scale approach could be used whereby the highest priced providers are permitted to grow at a slower rate than the lowest priced providers.

Reference Pricing

- **Definition:** Price for a given health product or service is based on an established, published external source. All providers or all insurers could be required to charge or pay the benchmark price or within a percentage threshold of the benchmark price.

Reference Pricing

Implementation Options

- Implementation can apply to a broad range of health services or be targeted just towards those services with strong evidence of clinical equivalence across providers. The focus could be on high cost or high volume services.
- Reference benchmarks could be obtained from a variety of sources including Medicare or existing market data.
- Reference pricing could include acceptable ranges of variation from the external source to be set through negotiation.

Rate Setting

- **Definition:** Establish a schedule of health care service prices that must be charged by providers or paid by payers.

Rate Setting

Implementation Options

- Rate setting has typically been applied to inpatient services only, but rates could be set for all services which are subject to negotiation.
- Rate setting methodology could be based on the methodology of other payers. The Medicare inpatient prospective payment system (IPPS) pays most acute hospitals in the nation a fixed base amount with additional payments in the form of factors that adjust for regional differences in costs and patient severity. It could also be set on a per-diem basis, unit cost, or global payment level. It could account for factors that contribute to cost, quality, or outcomes.

Next Steps: Meeting 5

- Discussion continues on potential strategies to reduce provider price variation

Special Commission on Provider Price Reform

August 17, 2011

Agenda

- Welcome
- Discussion of Potential Strategies to Reduce Disparities in Payment Rates
- Next Steps

Potential Strategies

- ✓ Price Transparency
- ✓ Market Power Intervention
- ✓ Consumer Incentives
- o Benchmarks for Variation
- o Acceptable Factors for Variation
- o Price or Price Growth Thresholds
- o Reference Pricing
- o Rate Setting

Final Principles for Provider Price Reform

- The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.
- Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.
- Provider prices may vary.
- Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.
- When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.
- Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.
- Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.
- Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
- Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.

Benchmarks for Variation

- **Definition:** Limits the amount of variation that an individual payer permits for a given service or market basket of services across the payer's network.

Benchmarks for Variation

Implementation Options

- Permissible price variation could be defined in terms of the percentage variation from high to low or around a baseline within a payer's network. Individual providers and payers could negotiate within the pre-defined limits.

- Contracts and payment practices could be monitored to ensure compliance.

Acceptable Factors for Variation

- **Definition:** Specifies the components for which variation is acceptable and could define the extent of component variation. This method could prohibit variation in price due to any other reason.

Acceptable Factors for Variation

Implementation Options

- Factors could be determined as acceptable sources of price variation. There are at least two possible implementation and enforcement mechanisms:
  - Insurers and providers may negotiate prices and determine specific application of factors without oversight, but maintain the ability for the state to review contracts and request justification for provider price variations. Such justification would have to be based on the acceptable factors, if not, the contract would need to be re-negotiated.
  - Determine the range of variation allowed for each factor. Provider contracts could be reviewed to ensure that provider price variation falls within acceptable limits. Permissible variation could be determined at the individual provider level, or broadly for all providers within a certain category.

Price or Price Growth Thresholds

- **Definition:** Establishes a ceiling on the allowable price for any given service or aggregation of services, or sets an allowable threshold for price increases.

Price or Price Growth Thresholds

Implementation Options

- *Price threshold:* There could be a threshold set on unit prices, bundled payments, global payments, or a price for a market-basket of services. Price threshold could be imposed on all services for all providers. Existing market prices could be used as a baseline and limit future growth to a specified amount.

- *Price growth threshold:* There could be a threshold set on the rate of price growth for some or all providers. Thresholds could vary depending upon a provider's relative price or apply only to providers with the highest relative prices. A sliding scale approach could be used whereby the highest priced providers are permitted to grow at a slower rate than the lowest priced providers.

Reference Pricing

- **Definition:** Price for a given health product or service is based on an established, published external source. All providers or all insurers could be required to charge or pay the benchmark price or within a percentage threshold of the benchmark price.

Reference Pricing

Implementation Options

- Implementation can apply to a broad range of health services or be targeted just towards those services with strong evidence of clinical equivalence across providers. The focus could be on high cost or high volume services.
- Reference benchmarks could be obtained from a variety of sources including Medicare or existing market data.
- Reference pricing could include acceptable ranges of variation from the external source to be set through negotiation.

Rate Setting

- **Definition:** Establish a schedule of health care service prices that must be charged by providers or paid by payers.

Rate Setting

Implementation Options

- Rate setting has typically been applied to inpatient services only, but rates could be set for all services which are subject to negotiation.
- Rate setting methodology could be based on the methodology of other payers. The Medicare inpatient prospective payment system (IPPS) pays most acute hospitals in the nation a fixed base amount with additional payments in the form of factors that adjust for regional differences in costs and patient severity. It could also be set on a per-diem basis, unit cost, or global payment level. It could account for factors that contribute to cost, quality, or outcomes.

Next Steps: Meeting 6

- Discussion continues on potential strategies to reduce provider price variation
- Formation of initial recommendations

Special Commission on Provider Price Reform

September 21, 2011

Price Variation Reduction Options for Commission Consideration

- The following five recommended strategies were developed for Commission consideration by Commission consultants.
- Strategy development was informed by prior Commission discussions and input gathered through meetings with stakeholders not participating directly on the Commission.
- The strategies are presented as a group that would be implemented together. It would be possible, however, to pursue some but not all of them.

Strategy Options for Commission Consideration

1. Increase transparency related to price variation
2. Continue oversight of competition in the health care system
3. Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions
4. Research acceptable and unacceptable factors for variation, and then formally consider such factors in contracting
5. Incrementally reduce price variation over time to meet 'benchmarks'

Principles	Options to Reduce Provider Price Reform
The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.	Increase Transparency Consumer Incentives
Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.	Consumer Incentives Acceptable Factors for Variation
Provider prices may vary.	Acceptable Factors for Variation Benchmarks for Variation
Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.	Increase Transparency Acceptable Factors for Variation
When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.	Continued Market Oversight Acceptable Factors for Variation Benchmarks for Variation
Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.	Acceptable Factors for Variation Benchmarks for Variation
Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.	
Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.	Increase Transparency Continued Market Oversight Consumer Incentives Acceptable Factors for Variation Benchmarks for Variation
Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.	

Increase Transparency

- **For consumers,** insurers should publish real-time expected out-of-pocket costs for the most common health care services based on: a) provider-specific prices and b) coverage product-specific cost sharing requirements.
- **For consumers and providers,** insurers should make information available that explains how providers are categorized for tiered network and select network products.
- **For purchasers and providers**, insurers should make available provider-specific price data for the most common referral or prescribed services (including diagnostic testing).
- **For providers, purchasers, insurers, and consumers**, the state should facilitate access to the All-Payer Claims Database (APCD) to further analyze price variation.

Continued Market Oversight

- The Attorney General should continue to monitor the reorganization of the healthcare system, and take appropriate action to remedy anticompetitive dynamics in the health care market, including access consolidation or collusion of providers or ACOs.

Consumer Incentives

- The state should evaluate and publish reports on the impact of Section 32 of Chapter 288 of the Acts of 2010, which requires health plans to offer tiered and select network products to the individual and small group market. The analysis should assess the techniques used by insurers to create networks for such products, and the extent to which they consider provider clinical quality, quality of service, efficiency, price and any other variables. The analysis should also include a review of the impact of such products on:
  - cost, including premium trend;
  - quality;
  - enrollment volume and market share;
  - financial impact on consumers, including financial impact for low-income populations and patients with high medical expense;
  - price variation; and
  - changes in care-seeking behavior among patients.

Acceptable Factors for Variation

- There are both acceptable and unacceptable factors for variation in prices among providers. Quality, stand-by services, care coordination, and community-based services provided by allied health professionals may be among the acceptable factors for variation. Similarly, market power, and advertising expenditures may be among the unacceptable factors.
- An independent expert body should further specify acceptable and unacceptable factors for variation, minimally considering the following:
  - medical education;
  - stand-by services and emergency services;
  - services provided by disproportionate share hospitals or other providers serving underserved populations;
  - research;
  - care coordination;
  - community-based services provided by allied health professionals;
  - use of continued advancement of medical technology and pharmacology; and
  - quality.
- The expert body should quantify the maximum reasonable adjustment for each acceptable factor.

Acceptable Factors for Variation, cont.

- Variation in insurer-provider negotiated prices should be supported explicitly by factors that the expert body identified as acceptable for variation. Insurers may vary prices in negotiations to account for these factors, as limited by the maximum reasonable adjustment. The state should be empowered to intervene if contract prices vary beyond the maximum reasonable adjustment supported by the expert body's formal consideration of factors, with consideration of both high and low-end outliers.
- The state should evaluate and publish reports on the impact of the application of Acceptable Factors for Variation on price variation and health care premiums.

Benchmarks for Variation

- Insurers should be required to reduce provider price variation annually until variation meets a 'benchmark' total variation set by the independent expert body. The benchmark should represent the maximum reasonable variation, considering all acceptable factors for variation.
- Provider price variation should be considered in the context of all arrangements (e.g., fee-for-service, bundled payment and global payment) until the percentage of an insurer's business with a provider using alternative payment methods (e.g., global payment) exceeds an appropriate threshold. Once the threshold is exceeded, the requirement should apply only to alternative payment arrangements for providers being paid principally by the insurer with alternative payment methods.
- If a provider refuses to accept a rate within the range, then the automatic default rate for that provider should be the insurer's median price.

Commonwealth of Massachusetts

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services

Recommendations of the Special Commission on Provider Price Reform

Appendix D

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix D: Special Commission Meeting Minutes

Special Commission on Provider Price Reform
Meeting Minutes

Date: Monday, June 20, 2011
Time: 10:00 a.m. – 1:00 p.m.
Place: 2 Boylston St, 5th Floor, Daley-Berkley Conference Room

Meeting Attendees

Special Commission Members	Guest Speakers	Contractors
✓ Jay Gonzales (co-chair) ✓ Seena Carrington (co-chair) ✓ Amitabh Chandra ✓ Patrick Gilligan ✓ Tim Jens *(proxy for Lynn Nicholas, Massachusetts Hospital Association)* ✓ Eugene Lindsey ✓ Eric Linzer ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Steven Walsh	✓ Nancy Panaro, DHCFP General Counsel	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. The meeting opened with introductory remarks by Secretary Jay Gonzales at 10:09 a.m. Secretary Gonzales noted that the Special Commission is getting started later than originally planned and because of that, the Special Commission will have an aggressive schedule to maintain. He thanked all of the Commission members in advance for working toward finalizing a report by September, 2011.

II. Introduction of Special Commission members and consultant

The Special Commission members introduced themselves and identified which organizations they represent. Acting Commissioner Seena Carrington introduced Michael Bailit, the consultant to the Special Commission.

III. Special Commission's role and responsibilities

a. Overview of statute (Section 67 of Chapter 288 of the Acts of 2010)

Nancy Panaro, the General Counsel for the Division of Health Care Finance and Policy, reviewed the key provisions of Section 67 of Chapter 288 of the Acts of 2010, which created the Special Commission. Commissioners were reminded that the goal of the Special Commission is to investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers. The Special Commission will examine policies aimed at enhancing competition, fairness, and cost-effectiveness in the health care market through the reduction of reimbursement disparities. The Special Commission shall develop recommendations that will consider, and be consistent with, the recommendations of the Special Commission on the Health Care Payment System, as created under Section 44 of Chapter 305 of the Acts of 2008. The Special Commission shall examine: the variation in relative prices paid to providers within similar provider

groups, the variation in costs of providers for services of comparable acuity, quality and complexity; the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses; the correlation between the price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payer mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs; the correlation between the price paid to providers and status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and policies to promote the use of providers with low health status adjusted total medical expenses. Any recommendation by the Special Commission requires a majority vote.

The Special Commission is required by legislation to consult with the office of the Attorney General, Health Care Quality and Cost Council, Division of Health Care Finance and Policy, health care economists and other individuals or organizations with expertise in state and federal health care payment methodologies and reforms. The Special Commission is also required to consult with different health care stakeholders throughout the state. Additionally, the Special Commission was reminded that their meetings are subject to the open meeting law. The Special Commission members are also subject to the state's ethics laws.

b. Process and expectations

Acting Commissioner Carrington also noted that because of the aggressive timeframe, the meetings will be highly structured. To that end, the Acting Commissioner asked that all Commissioners respect the diversity of opinions that are represented at the table and be civil and productive throughout the process. She also specifically noted that the Division of Health Care Finance and Policy has committed resources towards completion of the necessary data and analysis. DHCFP was also able to quickly put together a webpage for the Commission, where the meeting schedule, materials, and minutes will be posted.

IV. Review of Recommendations by the Special Commission on the Health Care Payment System

Michael Bailit reviewed the recommendations of the 2009 Special Commission on the Health Care Payment System. That Special Commission was created under Section 44 of Chapter 305 of the Acts of 2008. Its goal was to investigate reforming and restructuring the payment system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care. Bailit reviewed the Special Commission's process and highlighted the principles for payment reform. Bailit noted that the Special Commission on the Health Care Payment System unanimously recommended that global payments become the predominant form of payment to providers in Massachusetts. Bailit also noted that the recommendations included responsibilities for an oversight entity to: establish transition milestones and monitor progress, with a focus on the progress to global payments, progress to greater payment equity, and per capita health care costs; set milestones for achievement of value-based payment equity and monitor market progress toward these targets. Metrics for monitoring might include (a) variation in levels of risk-adjusted global payments to ACOs across payers and (b) variations in levels of payments to different providers within ACOs, and payments for lines of services such as primary care and behavioral health and other services. The oversight entity will have authority to assist, intervene, and make mid-course corrections if needed.

V. Principles for Provider Price Reform

Bailit facilitated a discussion of provider price reform principles. He first asked if the Commissioners could agree on the base assumption of the Special Commission's legislative mandate which is: reduction

in the variation of provider health care reimbursement will enhance competition, fairness, and the cost-effectiveness of the health care market.

The Commissioners gave the following input to the base assumption:

- Depending on how reduction of price variation is accomplished, it is conceivable that those providers who are less well advantaged get an increase in rates. This approach would result in less variation, but not in cost-effectiveness.
- How enhanced competition and fairness are achieved is important. Competition and fairness must be achieved without negative consequences.
- If variation is a problem, then must conclude that someone is being paid wrong. We might not agree on who is being paid accurately, but need to consider what the right price is for any given service.

Bailit then asked the Commissioners if they feel that a reduction in variation is desirable. The Commissioners responded with the following comments:

- Reduction in unjustified variation is important, but it must be done in a reasonable manner.

Bailit asked the Commissioners to discuss principles that should guide the work of the Special Commission. The principles were recorded and will be discussed again at the second meeting.

As a result of the principles discussion, the following topics or concepts were mentioned and placed in a "parking lot" for later review.

- Cost and price are affected by level of supply and therefore attention needs to be given to how much supply is necessary.

A revised draft of principles will be provided to the Special Commission after staff and consultants have obtained stakeholder input.

VI. Proposed work plan

Bailit reviewed the proposed work plan for the Special Commission including future meeting topics. The next two meetings will consist of data analysis and literature review, followed by a review of provider price reform options. Bailit asked that if any Commissioner wanted a specific reform option to be presented, s/he should communicate that option to one of the co-chairs.

VII. Next steps

The next meeting is scheduled for July 13, 2011.

The meeting was adjourned at 12:32 pm.

Special Commission on Provider Price Reform
Meeting Minutes

Date: Wednesday, July 13, 2011
Time: 9:00 a.m. – 1:00 p.m.
Place: 2 Boylston St, 5th Floor, Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Guest Speakers	Contractors
✓ Jay Gonzales (co-chair) ✓ Seena Carrington (co-chair) Amitabh Chandra *(absent)* ✓ Patrick Gilligan ✓ Eugene Lindsey ✓ Eric Linzer ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Steven Walsh	✓ Susan Brown, Assistant Attorney General, Office of the Attorney General, Health Care Division ✓ Stacey Eccleston, Assistant Commissioner of Health Research and Policy, Division of Health Care Finance and Policy ✓ Michael Grenier, Pricing Policy Manager, Division of Health Care Finance and Policy ✓ Stephen McCabe, Assistant Commissioner of Health Care Finance, Division of Health Care Finance and Policy	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. The meeting opened with introductory remarks by Secretary Jay Gonzales at 9:16 a.m. Acting Commissioner Seena Carrington then reviewed the agenda for the meeting.

II. Special Commission on the Provider Price Reform: Review of Objective and Scope

Michael Bailit reviewed the statutorily defined objective of the Special Commission on Provider Price Reform to investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers.

Michael Bailit also reviewed the statutorily defined scope of the Special Commission on Provider Price Reform to examine policies aimed at enhancing competition, fairness, and cost-effectiveness in the health care market through the reduction of reimbursement disparities.

III. Review of Stakeholder Feedback

Michael Bailit reviewed the list of stakeholders with whom he had met prior to the second Special Commission meeting, including Health Care for All and other consumer advocates; members of the Massachusetts Hospital Association; members of the Massachusetts League of Community Health Centers, representatives of the Massachusetts Coalition of Nurse Practitioners, and members of the Massachusetts Association of Health Plans.

In conversations with stakeholders, Michael Bailit asked the following four questions:

1. To what extent is price variation a problem in health care (and why)?
2. What are the drivers of price variation in health care?

3. What overarching principles should the Special Commission adopt?
4. Are there possible solutions or strategies to reduce price variation that the Commission should consider?

A summary of the stakeholder feedback is available in a memo to the members of the Special Commission; it is located at: www.mass.gov/Eeohhs2/docs/dhcfp/g/p_r/Stakeholder%20feedback-07-13-2011.pdf

IV. Continued Discussion of Principles for Provider Price Reform

Michael Bailit shared with the Commissioners a draft set of principles for provider price reform and asked for review and comment. Secretary Gonzalez noted that the focus should be on overarching principles and not on conclusions or strategies to reduce variation. He assured the Commissioners that potential strategies would be discussed at future Special Commission meetings.

The floor was then opened for discussion of the draft principles. It was agreed that the draft principles be finalized at the third Special Commission meeting, after the Commissioners have had a chance to review the principles with their constituencies.

V. Background on the Massachusetts Health Care Landscape

Acting Commissioner Seena Carrington introduced the data portion of the meeting. The data analysis was informed by the direction provided in the statue, but she solicited suggestions for additional areas of analyses that may be helpful to Commissioners in their deliberations. She added that DHFCP would keep track of the requests and fulfill those for which data was available.

Stacy Eccleston, Assistant Commissioner for Health Research and Policy at the Division of Health Care Finance and Policy, reviewed data descriptive of the health care landscape in Massachusetts. She specifically reviewed the statistics of commercially insured population by insurance type, enrollment of members by insurance plan, payment method for commercial and public plans, trends in health care premiums, and trends in health care expenditures.

Michael Bailit reviewed the potential causes of health care price increases identified in literature, including: investments in new and emerging technology, labor costs, increasing demand, third party payment, decreased market competition, and service mix and provider mix. Michael noted that the literature does not compare these factors relative to one another and therefore the potential causes of health care price increases were not listed in ranked order.

Stephen McCabe, Assistant Commissioner for Health Care Finance at the Division of Health Care Finance and Policy presented data that examined the specific factors cited in the legislation, including:

- the variation in relative price paid to providers within similar provider groups;
- the variation in costs of providers for services of comparable acuity, quality and complexity, and
- the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses.

VI. Findings from the Attorney General's Examinations of Health Care Cost Trends and Cost Drivers Pursuant to G.L.c. 118G § 6 ½ (b)

Susan Brown, Assistant Attorney General, presented the findings from the Attorney General's examinations of health care cost trends and cost drivers. She noted that the analysis sought to answer four key questions:

- What type of variation exists in the commercial prices paid by insurers to providers?
- Are those variations adequately explained by value-based differences in the serviced provided?
- How are variations in prices paid related to overall health care costs?
- How are variations in prices related to payment methodology?

VII. Provider Price Variation Analyses

Michael Greiner, Pricing Policy Manager in the Division of Health Care Finance and Policy, continued with a review of price correlations as specified in the statute. He specifically reviewed:

- the correlations between price paid to providers and
  - the quality of care,
  - the acuity of the patient population,
  - the provider's payer mix,
  - the provision of unique services, including specialty teaching services and community services;
  - operational costs, including labor costs;
- the correlation between price paid to providers and, in the case of hospitals, status a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and

Michael Grenier presented supplemental analysis, including examination of public payer price variation, examination of role of volume on price variation, and multiple regression models to assess the combined effect of the considered factors.

Michael Bailit reviewed national research literature regarding other potential reasons for price variation not analyzed by DHCFP or the Attorney General's Office. He specifically examined literature findings relative to cost-shifting, market power, reputation, and differential pricing and what they revealed regarding potential reasons for price variation.

VIII. Next Steps

Acting Commissioner Carrington summarized the meeting by noting three key points:

- Increasing prices are the primary driver of higher health care spending.
- There are wide variations in the prices paid to providers for the same services.
- The causes for such variations are unclear.

Dolores Mitchell added a fourth take-away, and that was to thank the Division of Health Care Finance and Policy and the Office of the Attorney General for their tremendous efforts in better understanding and analyzing the MA health care delivery system.

The next meeting is scheduled for July 29, 2011. The meeting was adjourned at 12:57 pm.

Special Commission on Provider Price Reform
Meeting Minutes

Date: Friday, July 29, 2011
Time: 9:00 a.m. – 1:00 p.m.
Place: 2 Boylston St, 5th Floor, Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Guest Speakers	Contractors
✓ Secretary Jay Gonzalez (co-chair) ✓ Acting Commissioner Seena Carrington (co-chair) ✓ Amitabh Chandra ✓ Michael Caljouw *(proxy for Patrick Gilligan, BCBSMA)* ✓ Eugene Lindsey ✓ Eric Linzer ✓ Dolores Mitchell ✓ Kimberly Haddad (*proxy for Chairman Richard T. Moore)* ✓ Lynn Nicholas ✓ Chairman Steven Walsh	✓ Tom O'Brien, Chief, Health Care Division, Office of the Attorney General ✓ Stacey Eccleston, Assistant Commissioner of Health Research and Policy, Division of Health Care Finance and Policy	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. Welcome

The meeting opened with introductory remarks by Secretary Jay Gonzales at 9:13 a.m. He then reviewed the agenda for the meeting. He noted that the purpose of the meeting was not to debate different strategies, but rather to learn and understand the potential strategies to reduce disparities in payment rates. He asked that all Commissioners withhold their opinions of the strategies and limit their questions to clarification on the implementation or use of the strategy.

Secretary Gonzalez asked for a motion to approve the meeting minutes from June 20th and July 13th. Chairman Walsh made a motion to approve the minutes and Dolores Mitchell provided a second to the motion. The minutes were approved unanimously.

II. Review of Additional Stakeholder Feedback

Lynn Nicholas remarked that the stakeholder feedback, as presented by Michael Bailit in the last meeting, did not accurately capture the overall intention of the hospitals that had been convened by the Massachusetts Hospital Association. Lynn asked to read a statement that clarified the intentions of the Massachusetts Hospital Association and its members. Secretary Gonzalez and Acting Commissioner Carrington agreed to allow her amendment to the meeting summary. Lynn asked that her official record be added to the Division website. Secretary Gonzalez and Acting Commissioner Carrington agreed to post it online.

Michael Bailit reviewed the additional stakeholder feedback he received following the Special Commission's July 13th meeting. Michael Bailit held two additional stakeholder meetings: one with physicians gathered by the Massachusetts Medical Society and the second with health center executive directors gathered by the Massachusetts League of Community Health Centers.

A summary of the additional stakeholder feedback is available in a memo to the members of the Special Commission. The summary is located at: www.mass.gov/Eeohhs2/docs/dhcfp/g/p_r/Stakeholder_Feedback.pdf.

After summarizing the stakeholder feedback, Michael Bailit offered to all the Special Commissioners the opportunity to join the stakeholder meetings that will occur in August. Michael will be reviewing the potential strategies to reduce disparities in payment rates with each stakeholder.

III. Review of Revised Provider Price Reform Principles

Acting Commissioner Carrington noted that the revised draft provider price reform principles were emailed to the Special Commissioners in advance of the meeting in order to provide them the opportunity to review the principles with any constituents. After a period of discussion and edits proposed by different Special Commission members, Acting Commissioner Carrington proposed that for meeting #4, she and her team would draft another version of the principles for final consideration. She asked that all Special Commissioners submit to her additional recommended changes for her consideration by the end of the day on Monday, August 1, 2011. She said she would work on a revised version of the principles and distribute it to the Special Commissioners before the next meeting. She asked that the Special Commissioners be prepared to vote on the revised principles during meeting #4.

IV. Review of Analytical Findings and Additional Analyses

Assistant Commissioner Stacey Eccelston summarized the findings of the last meeting. She noted that no relationship was found between price and quality, acuity, payer mix, disproportionate share hospital status, provision of specialty services, community services, costs per case mix adjusted discharge, teaching status or volume. She noted that although some weak and moderate correlations were found, none of the factors analyzed were independently found to be significant predictors of higher or lower provider prices. Stacey Eccelston noted that in the absence of quantifiable relationships, it was reasonable to conclude that prices appear to be strongly influenced by other unexamined factors.

Stacey Eccelston reviewed the additional requested analysis. She reviewed the following items:

- medical loss ratios by plan type;
- the hospital price variation that exists when specialty hospitals are excluded from the analysis;
- physician group price variation that exists when pediatric physicians are excluded from the analysis;
- correlation of teaching status with inpatient hospital prices;
- the total hospital margins for acute facilities and teaching and community hospitals;
- the disproportionate share and all other hospital median total margin;
- acute hospital financial performance for fiscal year 2010;
- the trends of Massachusetts health plan profit margins and the actual margins in CY 2010; and
- the potential price saving scenarios by narrowing price variation for selected DRGs and physician services.

V. Recommendations of the Office of the Attorney General

Tom O'Brien, Chief of the Health Care Division of the Attorney General, reviewed the Attorney General's recommendation to address health care costs trends and cost drivers. In her analysis, the Attorney General sought to answer two questions:

1. How can market function be improved, and
2. How can care coordination be improved?

After conducting the analysis, the Attorney General made six recommendations. They are:

1. Promote tiered and limited network products to increase value-based purchasing decisions.
2. Reduce health care price distortions through temporary statutory restrictions until tiered and limited network products and commercial market transparency can improve market function.
3. Encourage consumers to select a primary care provider who can assist consumers in coordinating care based on each consumer's needs and best interests.
4. Promote coordination of patient care through primary care providers by recognizing the need to improve funding of care coordination to include the infrastructure necessary to coordinate care, and by giving providers timely access to relevant patient data regardless of their size or payment methodology.
5. Consider steps to improve the use of the all payer claims database ("APCD") by: (i) developing reports for providers and the public to guide development of patient care coordination improvements and system accountability, and (ii) increasing the standardization of claim level submissions by reducing differences in how payers report payment level information.
6. Develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations.

VI. Potential Strategies to Reduce Disparities in Payment Rates

Acting Commissioner Carrington introduced the following discussion on the potential strategies to reduce disparities in payment rates. She noted that there were eight options to be presented and that these options were merely researched strategies – not recommendations. She also noted the eight options were not mutually exclusive. She asked the Commissioners to refrain from providing opinions on the strategies but rather ask clarifying questions with the intention of learning. She noted that in the following Commission meetings, the Commissioners would have the opportunity to discuss the strategies.

Candace Reddy noted that if the Commissioners had more suggestions or additional strategies, to please send them to Acting Commissioner Carrington and Secretary Gonzalez.

Michael Bailit presented each strategy and responded to questions after each strategy. The minutes are outlined with the strategy, the definition and subsequent discussion. For a full review of the strategies, please refer to the presentation posted at: www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_3. Michael Bailit noted that the names of the strategies were simply there to help identify the strategies and suggested that the Commissioners should not debate the names.

VII. Recent Proposals to Address Price Variation

Michael Bailit reviewed three current proposals that seek to reduce the disparities in provider price. He reviewed proposals by Governor Deval Patrick, Ellen Zane, President and CEO of Tufts Medical Center

and the Massachusetts Association of Health Plans. A summary of each of the proposals is available here: www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_3.

VIII. Next Steps

Acting Commissioner Carrington began to wrap up the meeting by noting that it was important for the Special Commission to finalize the principles as they would be the basis by which the Special Commission would evaluate the strategies and proposals that were discussed during the meeting.

Acting Commissioner Carrington also noted that the discussion during the fourth Special Commission meeting would revolve around pros and cons of each strategy and she asked each Special Commissioner to spend some time thinking about what strengths and weakness existed for the presented options.

Acting Commissioner Carrington asked that all Special Commissioners also review each strategy for use in a fee- for-service payment model and with alternative payment models. She noted that some recommendations required substantial lead time, while some other strategies might not. She closed by stating that the next three meetings will be comprised of deliberations and hopefully by the seventh meeting there will be a vote on recommendations.

The meeting was adjourned at 12:36 pm. The next meeting is scheduled for August 15, 2011.

Special Commission on Provider Price Reform

Meeting Date, Time, and Location
Date: Wednesday, August 15, 2011
Time: 10:00 a.m. – 1:00 p.m.
Place: China Trade Building | 2 Boylston St | 5th FL | Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Contractors
✓ Secretary Jay Gonzalez (co-chair) ✓ Acting Commissioner Seena Carrington (co-chair) ✓ Amitabh Chandra ✓ Patrick Gilligan ✓ Eugene Lindsey ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Lora Pellegrini *(proxy for MAHP)* ✓ Steven Walsh	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. Welcome

Secretary Gonzalez welcomed all of the Commissioners and called the meeting to order at 10:13 am.

The meeting minutes from July 29, 2011 were approved unanimously.

Acting Commissioner Carrington noted that the purpose of the meeting was to discuss the relative merits of the strategies to reduce provider price disparities.

Secretary Gonzalez mentioned that the meeting on Wednesday is in reserve depending on how many strategies the Commissioners discuss. He reminded the Commissioners that today's objective was not to arrive at a final recommendation, but rather to discuss the merits of each strategy to then inform a meeting in September where the Commissioners will begin to discuss potential recommendations.

II. Review of Principles of Provider Price Reform

Michael Bailit reviewed the draft principles of provider price reform:

1. The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.
2. Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.
3. Provider prices may vary.
4. Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.
5. When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.
6. Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.
7. Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.
8. Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
9. Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.

Michael Bailit asked the Commissioners for comments. A discussion ensued. Several Commissioners noted their support of the principles and a motion to approve the principles as presented was made. A vote occurred where eight members approved, one abstained, and one was absent.

- Eric Linzer, who was not present for the vote, submitted a statement asking to be recorded as voting in favor of the proposed principles.

- Lynn Nicholas asked that her abstention be recorded for the hospital's inability to support principle #5 (*when market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.)* The full text of MHA's abstention reason can be found online at: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_3

III. Discussion of Potential Strategies to Reduce Disparities in Payment Rates

Michael Bailit began the discussion by asking that the Commissioners note the individual strengths or weaknesses of each strategy. Commissioners would have a chance to consider strategies in relation to each other at a future meeting.

Michael asked the Commissioners to consider the following five points when debating the strategies:
1) consider ease of implementation;

2) timeline for impact;
3) expected effectiveness with respect to variation and cost;
4) the application of the strategy with alternative payment arrangements, and
5) the principles for provider price reform.

Michael asked the Commissioners whether there were any other factors that should be considered when debating the strategies to reduce price variation.

- Secretary Gonzalez suggested that the Commission looks at whether government or market is influencing the strategies. He noted that transparency is a strategy in which government has played a key role.

1. Transparency

Transparency was the first strategy reviewed. Price transparency requires the disclosure of prices in a manner that enables the consumer to make more informed care decisions.

2. Market Power Intervention

Market power intervention was the second strategy discussed. Market power intervention mitigates the competitive advantage of large provider systems. There are three ways the Commissioners looked at implementing market power intervention:

- *Regulation of contracting practices:* Regulation of provider negotiating and contracting practices could address:
  - Contract provisions that require payers to contract with all providers within a system, rather than contracting only with the individual provider facilities that a health plan may need to ensure adequate network access.
  - Contract provisions that require payers to pay the same or similar prices to all providers within a system.
- *Antitrust scrutiny:* Another approach could be closer anti-trust scrutiny by federal and state governments tasked with monitoring and regulating potentially anti-competitive behavior (Federal Trade Commission, Massachusetts Attorney General). Mechanisms for anti-trust scrutiny already exist, and could be applied more aggressively than has been historical practice.
- *Legislation:* Legislation could affect future market consolidation.

3. Consumer Incentives

The use of consumer incentives was the third strategy reviewed. Consumer incentives encourage patient choice for cost-effective providers. There are several strategies to implement consumer incentives and the Commissioners looked at the following proposals:

- Payers could continue to develop tiered and/or select network plans with reduced premiums or reduced cost-sharing.

- The Massachusetts Legislature has already mandated that health plans offer products that employ health benefit designs to engage patients more fully in choosing lower-cost providers. Additional actions could include:
    - Increasing required premium differentials between traditional network benefit programs and tiered/select network programs.
    - Specifying cost-sharing differentials between providers in and out of select network products and between tiered network products.
    - Limiting the ability of providers to opt out of tiered network products.
    - Specification of criteria that insurers must use to determine providers' eligibility for the select network.

IV. Next Steps

Secretary Gonzalez indicated that a meeting on Wednesday, August 17, 2011 would be necessary to continue the discussion. Secretary Gonzalez and Acting Commissioner Carrington thanked the Commissioners and adjourned the meeting at 12:48.

The next meeting will be held on August 17, 2011.

Special Commission on Provider Price Reform

Meeting Date, Time, and Location
Date: Wednesday, August 17, 2011
Time: 10:00 a.m. – 1:00 p.m.
Place: China Trade Building | 2 Boylston St | 5th FL | Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Contractors
✓ Secretary Jay Gonzalez (co-chair) ✓ Acting Commissioner Seena Carrington (co-chair) ✓ Amitabh Chandra ✓ Patrick Gilligan ✓ Eugene Lindsey ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Lora Pellegrini *(proxy for MAHP)* ✓ Steven Walsh	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. Welcome

Secretary Gonzalez welcomed all of the Commissioners and called the meeting to order at 10:05 am.

II. Stakeholder Feedback

Michael Bailit met with three separate stakeholder groups since the last Commission meeting. With each group, he reviewed the eight strategy options to reduce provider price variation and obtained their input. The full text of stakeholder feedback can be reviewed at: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_3

III. Discussion of Potential Strategies to Reduce Disparities in Payment Rates

Michael Bailit led the discussion of the strengths and weakness of the potential strategies to reduce payment disparities. He reminded the Commissioners to consider the same five points as the prior discussion:

1) consider ease of implementation;
2) timeline for impact;
3) expected effectiveness with respect to variation and cost;
4) the application of the strategy with alternative payment arrangements, and
5) the principles for provider price reform.

1. Benchmarks for Variation

"Benchmarks for Variation" was the first strategy reviewed during this meeting. The strategy limits the amount of variation that an individual payer permits for a given service or a market basket of services across the payer's network.

2. Acceptable Factors for Variation

"Acceptable Factors for Variation" was the second strategy reviewed during this meeting. The strategy specifies the components for which variation is acceptable and could define the extent of component variation. This method could prohibit variation in price due to any other reason.

3. Price or Price Growth Thresholds

"Price or Price Growth Thresholds" was the third strategy reviewed during this meeting. This strategy establishes a ceiling on the allowable price for any given service or aggregation of services, or sets an allowable threshold for price increases.

4. Reference Pricing

"Reference Pricing" was the fourth strategy reviewed during this meeting. Reference pricing is a price for a given health product or service is based on an established, published external source. All providers or all insurers could be required to charge or pay the benchmark price or within a percentage threshold of the benchmark price.

5. Rate Setting

"Rate Setting" was the fifth strategy reviewed during this meeting. "Rate Setting" is the establishment of a schedule of health care service prices that must be charged by provider or paid by payers.

IV. Next Steps

Secretary Gonzalez and Acting Commissioner Carrington thanked the Commissioners and adjourned the meeting at 12:02 pm. The next meeting will be held on September 21, 2011.

Special Commission on Provider Price Reform
Meeting Minutes

Date: Wednesday, September 21, 2011
Time: 10:00 a.m. – 1:00 p.m.
Place: China Trade Building | 2 Boylston St | 5th FL | Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Contractors
✓ Jay Gonzales (co-chair) ✓ Aron Boros (co-chair) ✓ Patrick Gilligan ✓ Eric Linzer ✓ Lynn Nicholas ✓ Amitabh Chandra ✓ Jenny Nathans (proxy for Rep Walsh) ✓ Kimberly Haddad (proxy for Senator Moore) ✓ Lynn Nicholas ✓ Eugene Lindsey	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. Welcome

Secretary Gonzalez welcomed everyone and called the meeting to order at 10:12am. The Secretary recognized Kim Haddad who participated on behalf of Chairman Moore and Jenny Nathans who participated on behalf of Chairman Walsh. Secretary Gonzalez then introduced and welcomed Aron Boros, the new Commissioner of the Division of Health Care Finance and Policy.

Secretary Gonzalez stated that the purpose of the meeting was to have discussion and deliberation of a draft set of options to reduce provider price variation. He noted that the five prior Commission meetings were focused on studying price variation, potential strategies to reduce variation and stakeholder feedback. He asked that the Commissioners share their opinions and the opinions of their constituents in response to the draft options.

The Secretary called on Michael Bailit to first provide the Commissioners with additional stakeholder feedback obtained between meetings five and six, and then present the draft options to reduce provider price variation.

II. Review of Stakeholder Feedback

Michael Bailit reported having had four conversations with stakeholder groups since the prior Special Commission meeting. He noted that the focus of those meetings was to share with stakeholders the eight strategy options the Commission had discussed and to solicit their feedback. A complete review of the stakeholder feedback can be obtained by following this link: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_6

III. Presentation and Consideration of Five Options

Michael Bailit shared with the Commissioners a group of strategies. The development of the strategy options was heavily informed by Commission meetings and stakeholder feedback. Michael said that the five strategies either had broad- based support or there were a significant number of Commissioners or stakeholders in support of the strategy. He noted that there were very few strategies that garnered unanimous support.

The following is a list of the draft strategy options presented to the Commissioners. To view the detail, please see the original presentation located here: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+Provider+Price+Reform&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_price_reform_work_plan&csid=Eeohhs2#meeting_6

1) Increase transparency related to price variation.
2) Continue oversight of competition in the healthcare system.
3) Evaluate the use and effect of products that increase consumer incentives to make cost-effective healthcare decisions.
4) Research acceptable factors and unacceptable factors for variation, and then formally consider such factors in contracting.
5) Incrementally reduce price variation over time to meet 'benchmarks.'

1) Increase transparency related to price variation

Michael noted that this strategy had four components.

1) Insurers should increase consumer transparency through the publishing of real-time expected out-of-pocket costs for the most common healthcare services.
2) Insurers should make available information that explains how providers are categorized for tiered and select-network products.
3) Insurers should make available provider-specific price data for the most common referral or prescribed services (including diagnostic testing).
4) The state should facilitate access to the All-Payer Claims Database to further analyze price variation.

After Michael reviewed the strategy and its four components, the Commissioners discussed this strategy. At the close of the discussion, Michael summarized the Commissioner feedback and noted that he had heard support for this strategy.

2) Continue oversight of competition in the healthcare system

Michael reviewed the second option to reduce provider price variation as the following: the Attorney General should continue to monitor the reorganization of the healthcare system, and take appropriate action to remedy anticompetitive dynamics in the healthcare market, including excessive consolidation or collusion of providers or ACOs.

The Commissioners discussed this option and recommended that this strategy be discussed with the Attorney General before it be made a final recommendation. Lynn Nicholas suggested that oversight of competition should include payers and not just providers.

3) Evaluate the use and effect of products that increase consumer incentives to make cost-effective healthcare decisions.

The third option presented called for the state to evaluate and publish reports on the impact of Section 32 of Chapter 288 of the Acts of 2010, which requires health plans to offer tiered and select network products to the individual and small group market. The analysis should assess the techniques used by insurers to create networks for such products, and the extent to which they consider provider clinical quality, quality of service, efficiency, price and any other variables. The analysis should also include a review of the impact of such products on:

- cost, including premium trend;
- quality;
- enrollment volume and market share;
- financial impact on consumers, including financial impact for low-income populations and patients with high medical expense;
- price variation, and
- changes in care-seeking behavior among patients.

A discussion of this strategy by the Commissioners followed Michael's presentation. The Commissioners were generally supportive of the option.

4) Research acceptable factors and unacceptable factors for variation, and then formally consider such factors in contracting.

Michael began his explanation of this draft strategy option by noting that in the Special Commission's Principles for Provider Price Reform, the Special Commission agreed that some variation in healthcare is acceptable. He then noted that this strategy would call for an independent expert body to further specify acceptable and unacceptable factors for variation, minimally considering the following:

- medical education;
- stand-by services and emergency services;

- services provided by disproportionate share hospitals or other providers serving underserved populations;
- research;
- care coordination;
- community-based services provided by allied health professionals;
- use of continued advancement of medical technology and pharmacology, and
- quality.

Michael explained that the independent expert body should quantify the maximum reasonable adjustment for each acceptable factor. Carriers would then be required to make sure that variation did not exceed that permitted by the acceptable factors.

5) Incrementally reduce price variation over time to meet 'benchmarks.'

The fifth draft strategy option to reduce provider price variation was presented with the following three components:

1) Insurers should be required to reduce provider price variation annually until variation meets a 'benchmark' total variation set by the independent expert body. The benchmark should represent the maximum reasonable variation, considering all acceptable factors for variation.
2) Provider price variation should be considered in the context of all arrangements (e.g., fee-for-service, bundled payment and global payment) until the percentage of an insurer's business with a provider using alternative payment methods (e.g., global payment) exceeds an appropriate threshold. Once the threshold is exceeded, the requirement should apply only to alternative payment arrangements for providers being paid principally by the insurer with alternative payment methods.
3) If a provider refuses to accept a rate within the range, then the automatic default rate for that provider should be the insurer's median price.

IV. Report Development and Written Recommendations

Michael concluded his presentation of the five strategies to reduce provider price variation and said that he would take into consideration all of the Commissioner's comments and begin to draft a final report and recommendations for circulation prior to the last Commission meeting.

Secretary Gonzalez asked that all appointees attend the last meeting and stated that the goal of the final Commission meeting is to present the recommendations for final approval.

Meeting was adjourned at 12:58

Special Commission on Provider Price Reform
Meeting Minutes

Date: Wednesday, November 9, 2011
Time: 9:00 a.m. – 12:00 p.m.
Place: China Trade Building | 2 Boylston St | 5th FL | Daley-Berkley Conference Room

Meeting Attendees

Commission Members	Contractors
✓ Secretary Jay Gonzalez (co-chair) ✓ Commissioner Aron Boros (co-chair) ✓ Patrick Gilligan ✓ Eric Linzer ✓ Lynn Nicholas ✓ Amitabh Chandra ✓ Representative Steven Walsh ✓ Senator Richard Moore ✓ Lynn Nicholas ✓ Eugene Lindsey ✓ Dolores Mitchell	✓ Michael Bailit, Bailit Health Purchasing ✓ Megan Burns, Bailit Health Purchasing

Meeting Minutes

I. Welcome

Secretary Gonzalez called the meeting to order at 9:15am. He began by stating that voting to approve the prior meeting's minutes would not happen because the minutes had not been distributed to the Commissioners in a timely manner.

He then said that this meeting was the last meeting and thanked everyone for being productive and positive in the process. He noted that the Commission's charge was not easy and that there were very different perspectives. He reported feeling very good about the process and hoped that the Commissioners felt that way too.

Secretary Gonzalez noted the state has been extremely successful at implementing health care reform to improve access to care and that now the state is steeped in the effort of addressing costs, which continue to be a problem in Massachusetts and nationally. He said that health care costs are a significant problem that is crushing businesses, state government and families. He said that the state needs to take thoughtful steps to ensure everyone can have good access to care at costs that are affordable. He then cited specific examples of the increase in health care spending in Massachusetts and how that has impacted the state's budget. He also cited a report from the Blue Cross Blue Shield of Massachusetts Foundation that highlights that the public is also concerned with the health care costs. He mentioned that the report found that 88 percent of

people surveyed said that it "is very" or "somewhat important" that government take action on cost containment. He said that cost containment was part of what this Commission was about.

Secretary Gonzalez then made an observation that the Commission was tasked at looking at unjustified price variation as one factor in the rise of health care costs and said that there is a need to change the way health care services are paid for in the state of Massachusetts. He said that the Governor sees the way we deliver and pay for care as a top priority.

Secretary Gonzalez then discussed the process of the meeting. He said that the report in front of the Commissioners was inclusive of the discussion heretofore involving both the Commissioners and stakeholders. He stated that he would call for a series of votes on the report, the first of which being a vote on the entire report exclusive of the six recommendations. The remaining votes would be on each recommendation individually. He noted that he would like discussion on each of the recommendations and would accept technical edits to the report. He said that to the extent a Commissioner had greater objections to the recommendations, he or she should state them during the discussion and that their concerns would be reflected in the minutes of the meeting, which will be part of the final report.

He noted that the Commissioners would have a chance to review the final report inclusive of any technical edits that were suggested and of the meeting minutes.

Secretary Gonzalez noted that motions to approve each of the sections of the report should also grant authorization for the co-chairs to make technical edits before finalizing the report. He noted that there were a handful of technical edits he would like to make and would announce each of those as they arose in the discussion of the recommendations. He asked that the Commissioners submit to him any additional technical edits identified after the meeting and to do so by the end of the week.

- Gene Lindsey asked if the Commission members would have an opportunity to submit additional items into the Appendix.
- Secretary Gonzalez said there would be two more opportunities to provide input. The first opportunity was through providing technical amendments by the end of the week and the other was to review the minutes of the meeting. He said that he did not want additional materials or letters to be submitted for inclusion in the report.

II. Discussion and Vote on Report

Secretary Gonzalez said he was willing to accept a motion to approve the body of the report, exclusive of the recommendations, but inclusive of the appendix while reserving the right to make any necessary technical edits before finalizing the report.
Senator Moore made a motion to approve the body of the report and Lynn Nicholas provided a second to the motion.

There was no discussion and the body of the report was approved unanimously.

III. Discussion and Vote on Recommendations

Recommendation #1: Act upon the recommendations of the Special Commission on the Health Care Payment System to address the inflationary effects of price and volume.

Secretary Gonzalez said he was willing to accept a motion on the first recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve the first recommendation and Representative Walsh provided a second to the motion.

The Secretary then opened the floor for discussion.

- Eric Linzer expressed his wish to make a technical change to the recommendation by inserting "alternative payment models" in place of "global payment models."
- Secretary Gonzalez thanked Eric Linzer for raising his point said he believed that the recommendation was a worthy of a technical amendment.
- Lynn Nicholas voiced her support for the technical amendment.
- Representative Walsh expressed his view that global payments and alternative payments may not be the same. He gave the example that if an efficient fee-for-service model was to be considered alternative, he would not agree with the recommendation.
- Secretary Gonzalez replied that he did not view fee-for-service in the same light as alternative payments, but he asked the Commissioners to confirm that they agreed.
- Lynn Nicolas noted that under most global payment arrangements, fee-for-service is the underlying payment mechanism.
- Representative Walsh asked that the language be changed to "global payment or other alternative payment methodology."
- Eric Linzer said that MAHP did not consider fee-for-service payment to be an alternative approach.
- Secretary Gonzalez said that he understood the point and would make technical edits accordingly.

There was no further discussion and the recommendation was unanimously approved.

Recommendation #2: Increase transparency related to price variation

Secretary Gonzalez said he was willing to accept a motion on the second recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve the second recommendation and Representative Walsh provided a second to the motion.

The Secretary then opened the floor for discussion.

- Dolores Mitchell wanted it known for the record that the language in the first bullet of recommendation #2 "[l]arge health insurance purchasers, such as large employers, would

also benefit from having access to such information" should be moved up in the paragraph. She said the language was fine, but the placement in the paragraph suggested that consideration of large employers was an after-thought.

- Secretary Gonzalez said that it could be submitted as a technical amendment to be reviewed by the co-chairs.
- Patrick Gilligan remarked that he was very supportive of transparency efforts. He did note that there were some concerns he would like known relative to implementation.
    - He said that the requirement to have quality information provided real-time did not link up with the sentiment of having real-time information regarding deductibles. He thought that having quality provided real-time by insurers was out of place.
    - Patrick went on to say that it was important that the Commissioners understand the administrative burden of implementing this recommendation and suggested that timeline be established with enough lead time to allow payers to implement this recommendation.
    - Lastly, he said that he was supportive of transparency efforts for tiered networks, but was not sure how this information could be included on a website or of how it could be regulated.
- Secretary Gonzalez said that he recognized that payers may have a challenge with the reporting requirements found in this recommendation and was supportive of adding specific language around a timeline that recognized the work that will be necessary to provide the specified information.
- Senator Moore said he would be supportive so long as it did not give payers an unlimited amount of time.
- Eric Linzer concurred with Patrick Gilligan and noted that MAHP was supportive of transparency efforts. He had two comments relative to this recommendation.
    - First, he noted that there was a reference to global payments in absence of a reference to alternative payments. He suggested that where in the report the term global payments was used, that "or other alternative payment arrangement" be used as well.
    - Secondly, he wanted to make clear for the record that where possible, the resources of the HCQCC should be leveraged to help meet this recommendation.
- Senator Moore said he was supportive of reference to the HCQCC.

- Representative Walsh noted that in this recommendation the word "insurer" was used. He said that when he thinks of "insurer," he is thinking "payer." He suggested that when a provider becomes an ACO, they should be required to report the same thing.
- Secretary Gonzalez agreed that transparency requirements should apply to ACOs as well as insurers and payers. He went on to say that Eric Linzer's point about adding "or other alternative payment arrangements" was a technical edit that would be made throughout the report.
- Dolores Mitchell said that it appeared as if the patient / consumer was omitted from this recommendation and wondered if that omission was purposeful.
- Michael Bailit replied by saying yes, because there were other existing and newly proposed transparency vehicles for consumers and that the Special Commission members had specifically targeted parts of this recommendation at providers and purchasers.

- Dr. Chandra said that he supported this recommendation but wanted it to be known that consumer protection was necessary when giving real-time information on out-of-pocket costs to consumers. He suggested that there should be a way for the website to record the quote that was given to the patient at least for a year, so that consumers don't get into the situation where they are using the website but then receive services that cost more than anticipated.
- Dolores Mitchell responded by noting that what is reported online are simply estimates of what it might cost. She said that unexpected procedural complications and events can occur in a hospital and to be charged more in such an event is not fraud nor unfair.
- Eric Linzer added that contract terms might change in the course of the year and that depending on when a consumer reviewed the website versus the time they received services, the price may change.
- Dr. Chandra said that in that case, the website would not be helpful, as patients could not rely upon it.
- Representative Walsh said that the recommendation was for real-time information. He said consumer protection should be a purpose of this website and that real-time costs should be available.
- Secretary Gonzalez said that the obvious intent and goal was to provide consumers with more information and that it should be implemented to the greatest extent possible.

There was no further discussion and the recommendation was unanimously approved.

Recommendation #3: Ensure competitive market behavior

Secretary Gonzalez said he was willing to accept a motion on the third recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve the third recommendation and Representative Walsh provided a second to the motion.

Secretary Gonzalez shared with the Commissioners that he reviewed this recommendation with the Attorney General and that she was generally supportive of it, but did raise the point that there is a difference between regulating anti-trust actions versus anti-competitive behavior. Secretary Gonzalez noted that the Attorney General wanted it to be known that it was possible she may need additional tools and resources and that the oversight of certain anti-competitive behaviors may be better addressed by other agencies.

The Secretary then opened the floor for discussion.

- Lynn Nicholas noted that she was generally supportive of this recommendation. She offered a technical edit suggestion by asking that instead of the recommendation being provider-focused, that it be focused on the health care marketplace as a whole. She noted that payer consolidation far exceed that of provider consolidation.
- Secretary Gonzalez said that making it provider-focused was an oversight in drafting and added that he believed that there was consensus on this point.

- Patrick Gilligan replied and said that he was unclear of what Lynn Nicholas was recommending and asked that she articulate what specific remedy she was suggesting.
- Lynn Nicholas noted that there are behaviors on both the payer and provider side that needed to be corrected.
- Secretary Gonzalez noted that it was a technical amendment and that there was no objection to that particular reference to oversight.
- Patrick Gilligan asked if that amendment was particular to subsection A of the recommendation.
- Lynn Nicholas replied yes.
- Eric Linzer said that MAHP would not view the same technical amendment to subsection B as being acceptable.
- Lynn Nicholas disagreed and said that non-competitive provider contracting practices comes in a lot varieties including in proposed consolidation on the payer side. She said it would be fair to look at the entire marketplace.
- Secretary Gonzalez said to Eric Linzer that this error was an oversight in drafting.
- Eric Linzer replied by saying that he did not view this technical amendment as such and asked where in Section A would there be a reference to health plans.
- Secretary Gonzalez replied by saying in the heading of Subsection A he would strike the word "provider" so that the text would read "prioritize oversight of competition in the health care market." He then said in the second paragraph, he would again strike the word "provider" and "ACOs" so the text read: "[a]s the Commonwealth moves to payment and delivery reform the attorney general should also review and monitor consolidation and remedy any anti-competitive behavior."
- Lynn Nicholas said that this was all she was proposing.
- Eric Linzer said he disagreed with the proposed edit.
- With respect to subsection B, Lynn Nicholas provided an example of the South Coast Hospital System, which she described as one provider with three hospital campuses that contracts as one. She said it would be unfair for a system like that to get caught up in technical issues because of this recommendation and implementation of this recommendation needed to be sensitive to such situations.
- Patrick Gilligan replied that the hospital system was not always contracting as one entity. He went on to say that if this proposal is implemented, it should be reviewed to determine whether other not providers with multiple physical locations should be considered one entity or not.
- Lynn Nicholas noted that in the 4.5 years she had been with MHA, South Coast had always been one licensed provider.
- Dolores Mitchell said that the Commission did not have this discussion. She noted that in Oregon, the state does not permit institutions with separate physician locations to be licensed as one. She said that since the Commission had not discussed this point, that it would not be fair to put those recommendations into the report.
- Lynn Nicholas said the Department of Health should consider how they license entities in the future.
- Secretary Gonzalez said that the draft is clear about this recommendation and how we address this issue.
- Dolores Mitchell asked for clarification on what is meant by "it may be necessary to specify provider networks in contract."

- Secretary Gonzalez said that it was an acknowledgement that in a move to ACOs, it will be necessary to be specific on where care is given.
- Dolores Mitchell said "specify" means "identify."
- Secretary Gonzalez confirmed this understanding.
- Gene Lindsey noted that in the recent consolidation of Fallon and Atrius there was concern about Eastern MA rates being transferred to Western MA. He noted this recommendation specifically stated that that practice cannot happen.
- Patrick Gilligan agreed with Gene Lindsey and noted that the last sentence of the recommendation was not clear to him. He said that was not clear that the recommended prohibitions not be applied to global or alternative payment arrangements. He said that instead of the term "should not apply" that the term "may not apply" be used instead.
- Secretary Gonzalez said that unless there were objections to this, he would view Patrick Gilligan's suggestion as a technical amendment and that the point was that prohibition should be reconsidered in the new payment world.
- Eric Linzer reiterated what Patrick Gilligan had said and noted that the last sentence was intended to look at the marketplace in the future to see if these prohibitions made sense.
- Patrick Gilligan said that he did believe that the Commission was missing the opportunity to improve market behavior with respect to tiering. He noted that in Chapter 288 there is an opt-out provision for providers that will make it difficult for payers to introduce new tiered products. He asked that it be noted that he preferred to have a recommendation that would not allow providers to opt out.

There was no further discussion and the recommendation was unanimously approved.

Recommendation # 4: Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions.

Secretary Gonzalez said he was willing to accept a motion on the fourth recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve the fourth recommendation and Lynn Nicolas provided a second to the motion.

The Secretary then opened the floor for discussion.

- Eric Linzer noted that one item missing from the review of the impact of products was geographic or regional differences. He suggested that regional differences be considered.
- Secretary Gonzalez suggested that "location" should be considered in the list of factors.
- Representative Walsh noted that Chapter 288 made a major impact in the use of select and tiered network products and that the original recommendation was that tiered network products be 15 percent less expensive than commercial products, but that there was a compromise to make them12 percent less expensive. He expressed hope that with this evaluation, it would be possible to move tiered network products to be 20 percent

less expensive or by even a larger percentage. He reiterated that Chapter 288 was the single largest move to help with disparities.

- Eric Linzer said that if plans were to offer products that were more than 12 percent less expensive than an acknowledgement would need to be made that in order to reach those reductions that a health plan had to exclude certain providers. He noted that getting to 12 percent was challenging enough and recognized that increasing that differential would be beneficial to employers and consumers.
- Senator Moore noted that the payer community was also slow to participate in this fully and cooperatively and the issue was not just provider behavior. He said other parts of the community are dragging their feet, citing the lack of insurer participation in the Connector's Business Express program.
- Eric Linzer said that the scope of the Commission was to talk about provider price variation and not in which markets insurers chose to operate.
- Senator Moore said the legislature would deal with that issue later.
- Secretary Gonzalez asked to let the record reflect the comments and noted that the recommendation was to review the impact of Chapter 288 requirements on tiered networks to understand what impact they had on the market.

There was no further discussion and the recommendation was unanimously approved.

Recommendation #5: Research acceptable and unacceptable factors for variation and then determine how they could be applied to reduce unacceptable variation in provider prices.

Secretary Gonzalez said he was willing to accept a motion on the fifth recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve fifth recommendation and Representative Walsh provided a second to the motion.

The Secretary then opened the floor for discussion.

- Dolores Mitchell asked how would the independent body be selected and whether it would be appointed or whether the members of the body would be state employees or compensated in any way. She asked how this would be handled.
- Secretary Gonzalez said that the Commission would not make those decisions. He asked Dolores that if she had a view on this that she could voice it and would be reflected in the minutes. He noted that some details are left to be worked out.
- Gene Lindsey asked that the following technical change be made: the last sentence of the first paragraph which read "market power and advertising expenditures are among the unacceptable factors" should be changed to read as "market power and advertising expenditure may be among the unacceptable factors." He noted that it's quite possible that marketing may be a mechanism for providers who do not have large market share and may need marketing as a tool to be more competitive. He said that making a definitive statement of "are" as opposed to "may" was not in line with the spirit of this recommendation.

- Lynn Nicolas said that she agreed. She suggested that examples not be given and that the recommendation simply say there are acceptable and unacceptable factors. She said that a practical example would be the advertising of preventative services.
- Secretary Gonzalez said that the Commission was not equipped to make decisions regarding what were and were not acceptable factors and was asking an expert body to do so and said he would therefore accept this recommendation as a technical amendment. He suggested striking the second and third sentences of the first paragraph and adding quality, stand-by services, care coordination, community-based services, market power and advertising expenditures into the list of what should be studied.
- Dolores Mitchell said she was troubled by that recommendation. She said that in the PPACA, payers were held to a medical-loss ratio and providers should be held to the same standard.
- Secretary Gonzalez said that he did not disagree, but that the expert body should handle this question.
- Lynn Nicholas said that the Commission shouldn't make the decision of what is and what is not acceptable.
- Patrick Gilligan said he did not object to the technical amendment, but did note that what was drafted was reflective of the discussion during the Commission meetings. He said that these recommendations should be reflective of the discussion during the Commission meetings.
- Senator Moore suggested that rather than striking out quality, include it to reflect that it was the Commission's recommendation state that quality be a priority concern.
- Lynn Nicholas said that she agreed with Senator Moore's comment.
- Lynn Nicholas went on to say that she would like behavioral health added to the bullets that discussed special services. She said that behavioral health is an important issue in the state and that it should be specifically addressed.
- Representative Walsh said that he did not think that this particular recommendation represented a fine moment for this Commission. He said that the Commission was tasked to do this work and now it was being left up to someone else. To suggest that another Commission was needed to study this issue was problematic. He stated that the Governor thinks we're in a crisis mode and he agreed. He added that it was going to be hard to accommodate the request to have another Commission while plans and providers waited to do anything until the additional Commission came out with recommendations. He said that the work needed to happen right away. He expressed concern that this recommendation could prove to be a "poison pill" and that this recommendation would not allow the Governor, Senator Moore or the Representative to do the work necessary to contain costs.
- Secretary Gonzalez assured Representative Walsh that no one felt more urgency than the Governor and the Administration and those people around the table and in the room. He said that he did not view this recommendation as a delay tactic, but rather a recognition that the particular exercise of reducing price variation was extremely complex and that this recommendation was part of a number of strategies to reduce price variation. He noted that there were other short-term remedies within this report that would have an immediate impact on cost containment.
- Senator Moore said he did not view this recommendation as recommending another Commission.

- Dolores Mitchell noted that there was a minor omission in the minority membership of the independent body and requested that purchasers be added to the group.
- Lynn Nicholas said she supported Dolores's recommendation. She then said this independent body would perform important work that would lead to changes in the future. She said she would prefer to leave recommendations of the expert body vis a vis adjustments made to an insurer's median rate be left open. She said that it was important to quantify and determine how adjustments should be made and that the expert body may have other innovative recommendations that it should be allowed to suggest.
- Eric Linzer said that he viewed Lynn's suggestion as a substantive change, not a technical change. He said that just because the expert body was going to look at factors and determine what the median rate was didn't mean the provider would get that, but it would help set a benchmark.
- Eric Linzer went on to say that the elements addressed in this recommendation should all be stand-alone factors and should not be cross-subsidizing each other. He said that if a provider performed well on one factor and not another, that payers should not be making up the difference.
- Secretary Gonzalez reacting to Lynn Nicholas' comments said that the expert body had the flexibility to recommend implementation. He then noted that he intended to make technical edits including changing "are" to "may be" and adding purchasers to the list of membership on the independent body.

There was no further discussion and the recommendation was unanimously approved.

Recommendation #6: Incrementally reduce unjustifiable price variation over time to meet benchmarks.

Secretary Gonzalez said he was willing to accept a motion on the sixth recommendation of the Commission while reserving the right to make any necessary technical edits before finalizing the report.

Senator Moore made a motion to approve the sixth recommendation and Representative Walsh provided a second to the motion.

Secretary Gonzalez discussed the recommendation and wanted to clarify that the second-to-last paragraph, as written, was confusing and would require editing. He noted that he intended to make a technical edit to the paragraph to make it clear that the recommendation was to apply only to fee-for-service arrangements. He said this recommendation would not apply to payers and providers who were contracting with global payment arrangements.

The Secretary then opened the floor for discussion.

- Eric Linzer asked why the first part of this recommendation would apply to global and alternative payment arrangements and not the second part of the recommendation.
- Secretary Gonzalez said that benchmarking will be done, but that the second part of this recommendation, as intended to be implemented, was very specific to fees for particular services.

- Eric Linzer expressed the concern that market clout, price disparities and price variation exist under fee-for-service arrangements and global or alternative payment arrangements and was concerned that recommendation six would only apply to fee-for-service arrangements. He viewed this as a missed opportunity.
- Secretary Gonzalez said that it was generally inconsistent that if talking about measuring total medical expense, then there was no practical way to create benchmarks in bundled or global payment arrangements. He said the Commission had talked about the need to view this in the context of TME and in order to make this recommendation clearer and internally consistent, he intended to make the technical edit that would limit this recommendation to fee-for-service.
- Patrick Gilligan said he understood the Secretary's point, but that the technical edit, as proposed, changed the intent of the recommendation. He had understood this recommendation to apply to global and alternative payments arrangements. He said that the recommendation could refer to the range of services or specific contracts. He said that he did not see the same internal conflict within the recommendation that the Secretary had mentioned.
- Eric Linzer reiterated his comment. He said that from his standpoint, restricting the recommendation to fee-for-service rates was a major change that made it difficult for MAHP to support this recommendation. He said the earlier drafts that had been circulated indicated that this recommendation would apply to all payers in all payment arrangements. He then asked the Secretary for a few minutes to confer with his colleagues before the call for a vote.
- Secretary Gonzalez apologized for the draft recommendation being poorly written and said that it should have been written so that it did not apply to all payment arrangements. He said that it was not the intent. He did say that the first part of the recommendation was a strategy intended to address price variation in all types of arrangements and the second part of the strategy could only technically apply to fee-for-service arrangements. The Secretary expressed his willingness to allow the Commission to recess for a few minutes for Commissioners to confer with their colleagues.
- Commissioner Boros reminded the Commissioners of the first recommendation and its use of milestones to rack the impact of efforts to implement global payment and reduce related cost growth.
- Eric Linzer said this recommendation harkened back to the Special Commission on Payment Reform where some independent entity set benchmarks. He said that this Special Commission made a clear step to provide a method to transition toward alternative payment arrangements, but with the clear expectation that costs still needed to be under control. He said that if a part of this recommendation only applied to fee-for-service, then when payers and providers move to global or alternative payment arrangements all "bets would be off." He went on to say that in the prior drafts, in the conversation at Commission meetings and in the research and data that was presented that it was clear this type of recommendation needed to apply to all payment arrangements.
- Lynn Nicolas said she agreed with the Secretary's interpretation of this recommendation and added that the second paragraph was highly prescriptive. She said that global and alternative payment arrangements are adjusted for a variety of considerations including for acuity. She said that the proposed remedy cannot technically be applied to global and

alternative payment arrangements. She said that the Commission should be looking at extreme payment deviations and that she agreed with Commissioner Boros that extreme payment deviations were addressed in the first part of this recommendation. She said she was supportive of the technical amendment.

- Gene Lindsey said that he could see both sides. He said that he was not advocating for an "out" for global payment arrangements, but that if global payments cannot lower TME than they should stay under the same scrutiny as fee-for-service. He said that technical language could be amended to reflect that point.
- Secretary Gonzalez reiterated that the technical amendment would be drafted to say something to reflect that the recommendation process would only work in fee-for-service, but that to the extent alternative payments can viewed in the perspective of total medical expense that the recommendation would apply to those arrangements as well.
- Dr. Chandra agreed with Gene Lindsey. He said the second paragraph would be hard to implement with global payment.
- Secretary Gonzalez said that it would be impossible.
- Dr. Chandra said that provider group might start to offer a product which other provider groups may not offer and it would be hard to do a comparison. He understood Eric's point and as written, to the extent there are pricing anomalies related to market clout, those anomalies will creep back into alternative payment arrangements.
- Eric Linzer said the recommendation needed to deal with alternative payment models being part of the benchmark and that the suggested technical edit was a substantive change with which he was not comfortable.
- Patrick Gilligan replied that he appreciated the nature of the correction, but disagreed that the proposed methodology would not apply to global payment arrangements. He said that in fee-for-service arrangements, payers make adjustments and there are technical ways to calculate a median TME. He said that the TME reported to DHCFP can be adjusted for health status and age and that those adjustments could be applied to global payment arrangements. He reminded the group that fee-for-service was the underlying payment mechanism to alternative payment arrangements and cautioned the group that fee-for-service will still need to be considered during the transition from it being the primary payment method. He closed his statement by noting that he too had thought this recommendation would apply to global payments.
- Representative Walsh noted that in the reports of many, including the Attorney General's report, the only flaw with global payment models is that they are built on fee-for-service payments. He said that he didn't see a problem with the technical edit including alternative payment arrangements as defined by the state.
- Secretary Gonzalez thought that the discussion was productive and legitimate points were being made. He noted that everyone is concerned about unjustified price variation being baked into global payments. He proposed a technical amendment to clarify the language so that it included fee-for-service and to the extent possible and appropriate, it be applied to global and alternative payment arrangements.
- Dr. Chandra asked if the Secretary intended on removing the language about appropriate thresholds.
- Secretary Gonzalez replied that he would strike the third paragraph completely.
- Patrick Gilligan said he would benefit from comments from the Commissioners before a recess was granted. He noted that the group had focused heavily on variation and were

looking for something substantive to recommend. He said he appreciated the spirit and intent of the recommendation. He said he could envision the recommendation to be implemented in conjunction with principle seven *(Any strategy to reduce the variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences)*. He said that the intention of a provider appealing their rate based on quality sounded good and made sense, but quality could be politicized. He recommended that quality measures be evidence-based, perhaps NQF-endorsed, and that experts should be reviewing the appeals as opposed to DHCFP staff, especially if DHCFP was going to be in a position to grant rates above that to which the plan agreed.

- Secretary Gonzalez clarified that DHCFP would not make the decision, but rather an independent panel would make the decisions.
- Patrick Gilligan pointed out that in the recommendation there was a sentence stating that the panel would be staffed by DHCFP. He recommended adding the word "independent" in front of every instance of the word "panel." He said that it needed to be implemented in a way that the Division of Insurance would understand that third parties may be making decisions on the plan's behalf.
    - Patrick Gilligan went on to say that the title of the recommendation was labeled as reducing price variation over time to meet benchmarks. He said that benchmarks were not part of the revised form of this recommendation and offered a technical recommendation to remove "benchmarks."
    - Lastly, Patrick said that it was important that no exemptions be allowed. To do so would gut the entire recommendation.
- Secretary Gonzalez agreed that "independent" should be added to every instance of "panel" and agreed to reword the title to make it more accurate in its description.
- Dolores Mitchell asked if the independent body in Recommendation Five was the same as the panel in Recommendation Six.
- Secretary Gonzalez said that it was not necessarily so, but that it wouldn't preclude that from being so. He asked Dolores Mitchell to voice her opinion.
- Dolores Mitchell did not voice her opinion on the panels but did ask why the recommendation, unlike the prior one, was singling quality out as the only reason to justify a higher price; there may be other reasons.
- Senator Moore said that quality is never redundant.
- Secretary Gonzalez said that the recommendation was meant to be implemented in the short term. He admitted it was not perfect and that the fifth recommendation would take some time to sort out. He said that this was an attempt to ensure that at least on quality, prices be more closely correlated.
- Lynn Nicolas said that "providers" should mean all providers and not exclusively hospitals. She said that there are a great deal of costs that are not hospital-based, a point which is largely ignored. She said that the reference to providers should truly mean all providers, including highly paid physician groups and procedural providers.
- Gene Lindsey said it was clear that all Commissioners viewed the recommendation through different lenses. He said that from a physician's perspective, quality should be disconnected from price. He noted that in one study, high price was correlated with lower quality.

- Secondly, he said that the Commonwealth was in pain and that the state needed some relief – that relief being a cost structure that was sustainable and no longer a detriment to the citizens of the Commonwealth. He noted that the cost of care was impairing access, even in the context of global payments.
- He said that he liked the first part of Recommendation Six because it gave parties a reasonable mechanism to resolve many of the issues that can come and will give parties an opportunity to present their case.
- He said he could argue that the details of mechanisms to reduce variation were a bit too prescriptive, but that if facts were presented to an independent panel and that panel had the best interests of the state in mind, then providers and payers would deal with the results. Overall, he said this recommendation was good and remarkably close.
- He did add that he would like to see a modification that would give the panel a little more flexibility to allow for negotiation between the payer and the provider.
- He concluded by saying that the intent of the recommendation was correct and he would strongly support and approve this recommendation so that more substantive discussion on reducing costs can happen in the Legislature.

- Eric Linzer asked for a recess to confer with his colleagues.
- Secretary Gonzalez clarified that his technical change would get rid of the third paragraph in the recommendation and include something to convey that this recommendation would apply to fee-for-service and to the extent technically possible and appropriate, to global and alternative payment arrangements with a reference to the first part of the recommendation.
- Secretary Gonzalez said he would accept a motion to recess if there were no other comments.
- Lynn Nicholas asked for permission to express her concerns about this recommendation prior to a vote on recess. She said that MHA would oppose this recommendation and summarized her stated reasons as follows:
  - First, she said that the recommendation did not allow the market to make this work. She noted that the market had heighted scrutiny, transparency and expectations. She said that all of the remedies were based on data that were old.
  - Secondly, she said that recommended intervention preceded analysis of the reasons of variation. She said that it presumed that all variation was inherently bad. She said that she was interested in hearing what experts have to say about variation before any changes are made.
  - Thirdly, she said that this recommendation was administratively complex and would always be fraught with technical issues that would have unintended consequences. She said that government has limited resources and that the government should focus on how Medicaid pays. She said government should foster delivery system reform and enable payment reform, but not by putting together a highly prescriptive overlay on a system from which the market is moving away.
  - Her fourth point was that quality should be the number one factor, but perhaps not the only factor for reasons for price variation.
  - Her fifth concern was that this recommendation gave health plans too much influence. She said it put "the cart before the horse" and that it gave health plans

tremendous influence. She said that if a provider offered a rate that exceeded the median then a payer could take the provider to the panel. She said the recommendation did not address the low-end providers who have high government pay.
    - She concluded by saying that variation does exist in the market and some level of that is unacceptable, but the market should address the problem and we should do more analysis.
- Secretary Gonzalez said that the Commission had been presented with a lot of data and that there is some level of unjustified variation. He said that from his perspective, the recommendation does not conclude, as Lynn suggested, that all variation is bad. He said that this recommendation provided a process for a provider to make a case that higher prices are justified. He said that it also gave lower-paid providers some leverage. He said if providers believed their level of pay was below where it should be, then they could make their case in a way they don't currently have today.
- Lynn Nicolas replied by saying that in the first part of this recommendation, it referred only to the appeal process for when a provider exceeded the market-based median. She said that it did not refer to the inverse where a lower paid provider would benefit.
- Secretary Gonzalez replied and said to be clear, lower paid providers could benefit from this appeal process.
- The Secretary then asked for a motion to recess and Lynn moved.
- Patrick Gilligan said that he would benefit from hearing Dr. Chandra's comments prior to recess and asked Dr. Chandra to share his opinion.
- Dr. Chandra shared his opinion that the decisions will be left to the independent panel and will rely heavily on the expertise of the members. He felt that the largest unknown in this recommendation was who will make up the panel. He wondered if quality experts would be appointed.
    - He went onto say that he struggled with this recommendation in how it was written to focus on fee-for-service payment models. He said that if the Commission targets fee-for-service prices, then fee-for-service volume can increase. He then noted that fee-for-service will be eliminated in a few years and so this recommendation may not be sufficient.
    - He then said that he welcomed price variation and that he would even be open to welcoming more price variation so long as it reflected quality and liked that some group of experts would be able to decide whether price variation reflected quality if providers cannot reasonably demonstrate to health plans whether higher prices are reflective of quality.
    - He concluded by saying that perhaps Massachusetts could lead in creating new and better quality metrics.
- Secretary Gonzalez asked for motion to recess for three minutes and Gene Lindsey made such a motion.

The Commission broke for recess.

Upon on the reconvening of the Commission, Secretary Gonzalez clarified that Recommendation Six would be modified as follows:

- the title would be changed;

- all references to "panel" would be replaced with "independent panel," and
- paragraph three would be stricken and replaced with a paragraph that stated that the recommendation was for fee-for-service arrangements and to the extent possible and appropriate, be applied to global or other alternative payment arrangements, with a reference to the beginning part of the recommendation.

- Dr. Chandra said that he supported the technical amendment and wanted to clarify that he believed the second paragraph would also need to change so that it was not so fee-for-service-focused. He said he agreed with Patrick Gilligan's concerns that some of this recommendation could be implemented in a global payment world, but that language would need to be finessed to make that point clear.
- Secretary Gonzalez said that Dr. Chandra's point was exactly the point that had been debated during this meeting. He said for the Commission to rework this language here and now would be hard, if not impossible. He said the third paragraph was intended to deal with global payments and that the technical amendment he just described was intended to make the point that the process for reducing price variation could be revised for other payment arrangements.
- Eric Linzer asked to articulate a few points about this recommendation prior to the vote. He said that an important piece of this recommendation was the reporting and studying. He disagreed with the concerns that the recommendation was heavy handed and noted that in the second paragraph of Recommendation Six, the language gave plans and providers the opportunity to figure this out on their own. He said the second paragraph told plans and providers where the guideposts were and established boundaries, but that if the market itself cannot figure it out, the independent panel was there to help with the process.
  - He expressed the concern that the recommendations not be made only on fee-for-service payments. He said to make this right he would encourage the text to change so that it would apply to global payments and other alternative arrangements.
  - He said his hope for the Commission was for it to have been strong on recommendations, to deal with the problem of provider price variation and provide short-term relief for small employers and families. He said that the focus had only been on plans. He said that at some point, it would be crucial to get to the point the Attorney General made and that was the problem of market clout. He said it is important for the government to have short-term statutory authority to help make the market place operate in the way it should.
  - He concluded by saying that he would like to see a technical amendment that refers to all payment arrangements being held accountable to this recommendation and to the extent there are concerns that all payment arrangements cannot be, then a process needed to be developed to handle alternative payment arrangements.
- Representative Walsh said that he was sensitive to Eric Linzer's concerns, but also noted that most of the market is still on fee-for-service and that the Secretary's technical edit, as suggested, would apply to the majority of the market.

- Eric Linzer replied and said that he had concerns because there are news reports of certain plans and provider re-contracting into alternative payment methods and that "to the extent possible" is not appropriate language for this recommendation.
- Representative Walsh asked Eric Linzer what he thought "to the extent possible" meant.
- Secretary Gonzalez said the only way this process or a similar process would also apply to an alternative payment arrangements would be when it was only technically possible.
- Representative Walsh noted that Eric Linzer and Secretary Gonzalez were in agreement.
- Eric Linzer replied by saying that he would like to see a technical amendment that would state that a process would be developed for fee-for-service payment arrangements and alternative payment arrangements, without language suggesting that it could be impossible. He noted that DHCFP presented the Commission with reports that said unless something is done, market clout will creep into global payment arrangements. He said that a statement needs to come out of this Commission that says these recommendations will apply to fee-for-service and alternative payment arrangements.
- Gene Lindsey said that as a health care executive he was concerned that the Commission was solving a problem that exists right now, but not the one that will occur next year. He said that market power now distorts the market, but it could also undercut the market. He gave the example of health plans selling products at less than the expected medical loss ratio which provided immediate benefit to some people, but could have a deleterious effect on the long term.
    - Gene Lindsey reiterated that how the independent panel was composed was important and that those experts needed to be able to defend quality and the concept of a fair market across all products.
    - He agreed with Eric's concerns and went on to say that he assumed the panel in Recommendation Five was the same of that in Recommendation Six. He liked that Amitabh Chandra focused on that panel too and said that providers would have more confidence in this process if they believed that their appeals to quality were heard by panel experts that believed in the Institute for Health Care Improvement's Triple Aim.
    - He then referenced his prior example by saying that with a goal to have high quality and low costs a low cost product could undermine the care of individuals. He said that the Commission trusts a panel made up of unknowns and that he was willing to take the leap to instill trust in the panel.
    - He concluded by saying everyone believed that change needed to happen, but no one wanted to be the one to change. He said everyone had something to risk and that tension created a nice balance.
- Commissioner Boros asked to follow-up on the possibility to measure TME in global payment arrangements. He said that the DHCFP believed it was possible to measure TME and variation in global payment, but maybe not for every single arrangement, which was why he supported the language "to the extent possible" with a reference back to the first part of Recommendation Six.
- Representative Walsh said he believed if a plan and provider would enter into an agreement to usurp the spirit of this recommendation that the panel would have a problem with that behavior. He wondered if the Commission could move beyond this discussion and replace "to the extent possible" with "as determined by the panel."

- Secretary Gonzalez said he believed there was a lot more meaning being read into the words that he intended and suggested a technical edit be written that would recommend the process for fee-for-service and that a similar process should be applied to global or other alternative payment arrangements.
- Eric Linzer said he could agree with the Secretary's proposal.
- Lynn Nicolas had one final point to make and that was that she believed the Commission had wrongly focused on private payer disparity. She said that providers who are highly dependent upon government pay are short-changed and that everyone understands cost-shifting and no one denies that cost shifting happens. She said that there was no recognition of that in this report and that she wanted it to be known that adequate payment by government could reduce provider price variation.
- Secretary Gonzalez reminded Lynn Nicholas that the Commission had been presented with an analysis that showed no direct correlation between payer type and price variation. He said that her comments could be reflected in the minutes of this meeting and that her constituents voiced that concern, which will be reflected in the stakeholder feedback section of the report.
- Patrick Gilligan said that he appreciated the Secretary's language to develop a similar process for global and alternative payments. He wanted to articulate that his prior concerns about implementation relative to fee-for-service applied to global and alternative payments.
- Eric Linzer thanked the Secretary and the Commissioners for having a healthy discussion about this and wanted to make it known that he would hate to have a situation where a provider who was paid on a global payment demand a greater-than-10 percent increase and would like that to be taken into consideration. He then said he agreed with Patrick Gilligan's concerns with regard to implementation.
- Senator Moore wanted to clarify his view on how government pays. He said that if Medicare or Medicaid payments were increased that health care costs would still go up.
- Lynn Nicholas replied by saying that as we know payment today, Medicaid does not cover total costs and that there is a gap between costs and government pay.
- Senator Moore said that he could agree with Lynn on cost drivers and that ordering unnecessary tests adds to costs.
- Lynn Nicholas said that she was not referring to drivers, just the costs as they incurred for whatever reason.
- Senator Moore said that the government does not pay full cost in order to increase efficiency and that just changing the payment may not solve all of the problems because it does not deal with what price ought to be.
- Secretary Gonzalez thanked the Commissioners for the spirited debate and asked for the vote to take place by a show of hands.

The vote took place with nine Commissioners approving the sixth recommendation and one opposed. The opposing Commissioner was Lynn Nicholas.

IV. Meeting Summary and Conclusion

The Secretary said that the Commissioners could expect a version of the report, as approved, to be posted by later that day. He asked that if any Commissioners had technical edits to the report

that they submit those changes by the end of the day on 11-11-11. He said that the Commissioners would have a chance to review the meeting minutes and once finalized, a complete report would be posted, inclusive of the minutes.

Secretary Gonzalez specifically thanked former Acting Commissioner Seena Carrington, Commissioner Aron Boros and his staff, including Steve McCabe and Michael Greiner. He also thanked consultants Michael Bailit and Megan Burns. Finally, he thanked his colleague Candace Reddy for all of her work and support.

- Lynn Nicholas made a reciprocal statement and noted that the Commission was well run, transparent and the process used was fair. She thanked the co-chairs on behalf of all of the Commissioners.

Secretary Gonzalez adjourned the meeting at 11:50

Commonwealth of Massachusetts

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services

Recommendations of the Special Commission on Provider Price Reform

Appendix E

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix E: Stakeholder Feedback

E1. Stakeholder Feedback: July 13, 2011

E2. Stakeholder Feedback: August 17, 2011

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PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Members of the Special Commission on Provider Price Reform
FROM: Michael Bailit
DATE: July 13, 2011
RE: Stakeholder Input to the Commission

Introduction

In my role as consultant to the Special Commission on Provider Price Reform, I spoke with several stakeholder groups during the weeks preceding the Commission's July 13 meeting. The purposes of these meetings were to:

- educate the stakeholders about the Special Commission on Provider Price Reform, including its statutory basis, purpose, scope and timeline;
- describe the process by which the Special Commission seeks to engage stakeholders, and solicit their input at key junctures in the Special Commission's work;
- solicit perspectives on provider price variation in Massachusetts; and
- invite suggestions regarding potential provider price reform principles and strategies.

In the course of this work I met with members of the following stakeholder groups:

- community health centers;
- consumer advocates;
- health plans;
- hospitals; and
- nurse practitioners.

In addition, I am scheduled to meet with a group of physician representatives on July 14 and will be reaching out to the Massachusetts Municipal Association and to Taft-Hartley plans. Finally, my efforts to schedule a meeting with private employers through the leading business coalitions have thus far proved unsuccessful, but I will make additional efforts to consult with those stakeholders.

Each of the stakeholders with whom I met readily engaged in the topic, and in most cases had strong feelings regarding the topic of price variation. With some exceptions, I asked the stakeholders three questions:

1. To what extent is price variation a problem in health care (and why)?
2. What are the drivers of price variation in health care?
3. What overarching principles should the Special Commission adopt?
4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

As is reflected below, the stakeholders possessed some starkly contrasting perspectives. It is important to note that this summary has not been shared with the identified stakeholder groups(s).

Community Health Centers

I met with a group of community health center executives convened at my request by the Massachusetts League of Community Health Centers. The meeting was held prior to the first Special Commission meeting. I did not ask for suggestions regarding principles for price reform.

1. To what extent is price variation a problem in health care (and why)?

    - The community health center executives identified multiple examples of price variation, including:
        - 10% higher prices for hospital-licensed health centers as compared to non-hospital licensed health centers;
        - Teaching hospital practices being paid both professional and facility fees;
        - Larger providers with better contracts than the health centers; and
        - Specialists receiving prices dramatically better than primary care physicians.
    - The participants felt that this variation was problematic for the following reasons:
        - Health centers are losing physicians to providers who can pay the physicians better. For example, one health center reported losing a physician to a Boston teaching hospital-owned practice because the hospital could pay the physician 30% more than could the health center due to the higher prices it receives.
        - Health centers cannot hire enough primary care physicians, and increasingly, cannot hire any specialists at all, needing to refer patients in need of specialty care to teaching hospitals.

2. What are the drivers of price variation in health care?

    - The community health center executives quickly identified market power and brand recognition ("the perception of quality") as the primary factors driving price variation across providers. They noted that current provider consolidation activity is making the problem worse.

3. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

    - The meeting participants were not of one mind, and offered the following recommendations:

        - Prices should be consistent with a "same work, same pay" principle, with price variation only for quality, case mix, and socio-economic patient population status.
        - Highest paid providers should be capped or their rates of increase lowered in a regulatory fashion.
        - Regulate the extent to which insurers can vary their rates by provider.

Consumer Advocates

I met with a group of consumer advocates convened at my request by Health Care for All, consisting primarily of organization staff. The group did not have much perspective to offer on price variation,

its causes and the extent to which it is problematic. The consumer advocates did offer a number of suggestions for price reform principles, however.

1. What overarching principles should the Special Commission adopt?

    - Make price information transparent, readily accessible online and otherwise. The advocates emphasized that the information should be for consumers and not for "wonks" and that a website was not enough.
    - Address disparities in payment across service type and specialty for mental health and substance abuse service relative to other services.
    - Address the supply mix in medical education by creating prices that encourage more primary care and less specialty care.
    - Lower overall system cost.
    - Improve access and outcomes.
    - Adjust prices for quality outcomes.
    - Consider patient impact when designing and implementing strategies related to price.

<u>Health Plans</u>
I spoke via telephone with representatives of some member plans of the Massachusetts Association of Health Plans in separate interviews. I did not ask for suggestions regarding principles for price reform.

1. To what extent is price variation a problem in health care (and why)?

    - The health plan executives agreed that price variation is a problem. They reported that large and geographically dominant hospitals are paid more than other hospitals, creating differentials that don't make any sense from the plan perspective. This phenomenon is also found in the physician market and is worse than hospital price variation as large systems have focused on increasing physician compensation differentials.
    - The health plan executives felt that the identified price variation is problematic for two specific reasons.
        - Large systems with high prices "poach" physicians from other hospitals and physician groups. This practice destabilizes community hospitals.
        - Price variation has contributed to cost inflation. Providers with high prices have not been penalized for their high prices as would normally occur in a competitive market. Rather, they have been able to invest the added revenues and recruit physicians and other professionals with higher compensation thereby increasing patient volume. Conversely, low price providers have not been rewarded with increased market share.

2. What are the drivers of price variation in health care?

    - Market leverage was described as the primary driver of variation, with teaching status and provider payer mix minor considerations.
    - One health plan noted that most employee health benefit plans don't allow members to take advantage of differences in price as they can do in other markets. In health care the

member is largely shielded from realizing the economic consequences of his or her provider choice decision.

3. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   The following ideas came from different payers and do not represent a consensus among the interviewed health plans.

   - Prohibit physicians who don't practice on a hospital campus from billing under a hospital's tax identification number at the hospital's rates.
   - Specify that global payment rates be based on payer network averages rather than a hospital or medical group's own current reimbursement levels.
   - Support the Attorney General's "reset" proposal and address high price outliers. This would provide immediate premium relief, since premiums have grown in recent years primarily based on rate growth. This would also limit the efforts of systems to "poach" physicians from their competitors.
   - Limit how much hospitals can charge for outpatient services and physician services.
   - Prohibit physicians working in hospitals (e.g., anesthesia and radiology) and ambulances from refusing to contract with the health plan (and therefore demanding payment based on charges).
   - Modify statute and regulations issued by the Division of Insurance as a result of Chapter 288 which currently allow providers to opt out of new tiered network products.

Hospitals

I met with a group of hospital executives convened at my request by the Massachusetts Hospital Association. The hospitals included community and teaching hospitals from central and eastern Massachusetts and one major safety net hospital.

1. To what extent is price variation a problem in health care (and why)?

   - The overwhelming sentiment of these hospitals was that price variation is not a problem, and that the state's focus on price is misguided. One hospital representative noted that price variation exists in other markets and there was no reason it should not be present in health care.
   - Hospitals argued that "the only issue was the government paying its bills." One executive stated "we're underpaid for our base business – this is the issue – not commercial rates."
   - The hospitals felt they should be evaluated based on the total medical expense generated by their patient care, with appropriate adjustment for multiple factors, rather than on their prices.
   - One participant noted that it was faulty for the state to look at inpatient and outpatient prices separately, since hospitals strategically decide to price one higher relative to the other.
   - Only one hospital described price variation as an issue, but only as it pertained to physician rates and it causing Boston hospital-affiliated community physicians to

refer patients to Boston rather than to a geographically more proximate community hospital.

2. What are the drivers of price variation in health care?

   - The hospital representatives identified public payer underpayment, internal cross-subsidization, strategic positioning, and hospital costs as driving price variation.

3. What overarching principles should the Special Commission adopt?

   The participating hospitals recommended a number of principles for the Special Commission's consideration, including the following:

   - View the commercial market in the context of the broader market, i.e. recognize that pricing and hospital finances are influenced by the combined effect of private payer and public payer prices.
   - Align any recommendations with the requirements, policies and strategies of the PPACA, Group Insurance Commission, MassHealth, Connector Authority, and the Division of Insurance.
   - Engage consumers in effecting market-driven change, including through increased transparency.
   - Be sensitive to potential adverse consequences – "first do no harm."

4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   - The hospitals urged the Special Commission to not focus on commercial prices, specifically recommending against rate caps.
   - The hospitals instead advocated for market-based efforts, including global payments with transparency of price, quality and consumer restrictions and tiered networks. They also restated their call for government paying its "fair share."
   - Finally, the hospital representatives emphasized that reductions in prices will mean reductions in costs, and for hospitals that will require reducing their employee count of personnel who will have difficulty finding equivalent jobs.

<u>Nurse Practitioners</u>
I spoke via telephone with representatives of the Massachusetts Coalition of Nurse Practitioners (MCNPs).

1. To what extent is price variation a problem in health care (and why)?

   - Nurse practitioners view their smaller market power as reducing the prices that they receive from insurers.
   - Nurse practitioners believe that their prices are not reflective of the quality or complexity of the services that they provide.

2. What are the drivers of price variation in health care?

   The MCNP representatives identified the following drivers of price variation:

   - The traditional practice of insurers and Medicare is to generally reimburse nurse practitioners at 85 cents on the dollar compared to physicians. The MCNP reported this practice to be in contrast to Medicaid practice where a federal rule for Medicaid managed care contracting specifies that there must be equal pay for equal services.
   - Physicians can bill as having performed a service that they did not perform, thereby getting a higher payment rate for nurse practitioner services than the nurse practitioner can earn.
   - Nurse practitioners are being tiered in insurer tiered network products for the GIC as specialists rather than as primary care providers because carriers lack enough nurse practitioner data to tier based on performance.

3. What overarching principles should the Special Commission adopt?

   The MCNP recommended the following principles for provider price reform:

   - Equal pay for equal services;
   - Nurse practitioner scope of practice to the extent permitted by state law; and
   - Prices should vary based on clinical quality outcomes data and multi-disciplinary team coordination indicators, and not on productivity benchmarks.

4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   - Require by regulation that prices be negotiated based on clinical quality outcomes, and not based on consideration of quality process performance or productivity.
   - Prohibit insurer tiering of nurse practitioners as specialists.
   - Require carriers to report to the All-Payer Claims Database (administered by DHCFP) who provided services, rather than not just who billed for the care.
   - Prohibit hospital and physician group practice employers from limiting nurse practitioner scope of practice to something less than permitted by state law.

I will be holding a second round of conversations with each of the same groups following the Special Commission's third meeting to solicit reactions to the strategy options. I will then report back with stakeholder input at the Special Commission's fifth meeting.

Please feel free to contact me with any questions or suggestions, or if you should wish to attend any of the future stakeholder meetings.

- Some physicians felt that the strategies would not work, with a couple noting that they might hurt ACO formation.

3. Consumer Incentives

- The physicians had mixed perspectives regarding creating consumer incentives for provider choice through tiered and select networks. Some physicians felt that it was important to engage consumers. One physician recommended that tiering be done at the network (ACO) level rather than at the individual physician or practice site level.
- Those physicians who expressed concern regarding the strategy cited the following worries:
    - harmful financial effects on sick patients who must use the most expensive providers;
    - administrative complexities for providers of delivering care to patients enrolled in limited (select) networks;
    - how this strategy can work in the face of growing provider consolidation;
    - disadvantaging academic medical centers and thereby compromising their economic, quality and teaching benefits;
    - adverse impact on small physician practices, and
    - the need for physician-driven quality measures to inform network design.

4. Benchmarks for Variation

- A majority of the physician participants spoke favorably regarding this strategy. While noting that great care would need to be taken when developing the methodology, including consideration of special services and geographic differences in labor costs, they felt that this strategy would help Massachusetts take a big step towards increased fairness.
- The physicians noted that questions regarding who would set the range, how it would be set, and what would be the midpoint would all be crucial design considerations.

5. Acceptable Factors for Variation

- A majority of physician respondents also found this option attractive. They worried a little about implementation and possible unintended consequences, but felt that if there was a consensus set of factors that included quality, language and psycho-social patient characteristics (among other factors), it would work quite well.
- One physician advocated for setting a range for each acceptable factor.

6. Price or Price Growth Thresholds

- Most physicians did not like this strategy, although their reasons varied.
- Cited concerns included:

- the strategy felt like a step towards rate setting;
- perceived administrative difficulty to implement and then track and refine the strategy;
- the time it would take for the strategy to have a meaningful impact, and
- the viability of implementing the strategy with fee-for-service payment at a time of transition in payment models from fee-for-service to global payment.

7. Reference Pricing

   - Overall the physician respondents were lukewarm on this strategy.
   - A couple of physicians liked implementation of this concept for selected clinically equivalent services.
   - Two physicians made the point during this discussion that the biggest variation issue for physicians was not rate variation across payers, but rather the variation across physician specialties.

8. Rate Setting

   - While several physicians had voiced support for this strategy during my first meeting with the group one month earlier, seeing it as a way to achieve fairness, a change in perspective appeared to have occurred since that time. It appeared that in the context of the other potential strategy options that were introduced to them during this meeting, including "benchmarks for variation" and "acceptable factors for variation", rate setting was viewed in a less attractive light.
   - Members of the group did voice some continued support for rate setting as it might apply to global payments.

Finally, there were two messages that were not specific to any one strategy that were voiced by the physicians on multiple occasions. First, there was concern about the impact of efforts to reduce price variation on academic medicine. Specifically, there was concern that lowered prices for academic physicians would harm training programs, harm patient safety, and make physician recruitment and retention in academic settings more difficult. Second, it was noted on multiple occasions that the strategies could be combined to complement one another.

<u>Consumer Advocates</u>
As with the physicians, I reviewed the eight strategy options being considered by the Commission with a group of consumer advocates from a few different organizations including and convened by Health Care for All at my request. I received the following input, primarily from Health Care for All.

1. Transparency

   - The advocates felt that a transparency strategy could only work in conjunction with a consumer incentive strategy, since consumers would otherwise have no reason to consider price information when making care-

seeking decisions. They also noted that the fact that insurance covered most costs made transparency of limited impact.
- The advocates also noted that price transparency needed to be accompanied by quality transparency.

2. Market Power Intervention

    - The advocates liked the regulation of payer-provider contracting element of this strategy, particularly for its potential short-term impact.

3. Consumer Incentives

    - Advocates voiced strong opposition to this option for the following reasons:
        - physicians and not patients drive expensive care;
        - patients with chronic illnesses require care that is more expensive;
        - the products are confusing to consumers, and
        - the products adversely affect lower income and lower middle class patients.

4. Benchmarks for Variation
5. Acceptable Factors for Variation
6. Price or Price Growth Thresholds
7. Reference Pricing

    - The advocates did not speak to each of these options individually, but commented that they all represented promising ideas.

8. Rate Setting

    - Consumer advocates responded to this option stating that there was no denying that Maryland had succeeded with this strategy, as Massachusetts had once done, and that close consideration of Maryland's experience was warranted.

Finally, as an additional option for Commission consideration, it was suggested that the creation of a state health care capital plan might serve to indirectly reduce price variation.

<u>Purchasers</u>
After extensive efforts to convene a group of large employers, Taft-Hartley trusts and the Massachusetts Municipal Association, I was successful in gathering two large Massachusetts employers and a Taft-Hartley trust. They had diverse views.

Of the eight options being considered by the Commission, only Transparency (#1) and Consumer Incentives (#3) were viewed desirably by all three participants. One purchaser added that he would like to see health plans distribute price transparency information to enrollees rather than have the information just available through the state.

Regarding the remaining measures:

2. Market Power Intervention Strategy

    - Two purchasers supported this strategy when focused on payer-provider contracting practices.

4. Benchmarks for Variation

    - One purchaser supported this strategy and two did not.

5. Acceptable Factors for Variation

    - Two purchasers supported this option, and one did not.

6. Price or Price Growth Thresholds

    - One purchaser supported this strategy and two did not.

7. Reference Pricing

    - One purchaser supported this strategy and two did not.

8. Rate Setting

    - None of the purchasers were comfortable with this option.

Finally, one purchaser argued that the Commission should have looked at public payer price dynamics as well.

I will be holding my second round of conversations with hospital and nurse practitioner representatives later in the month. I will then report back to the Commission again with input from these stakeholder groups at the start of the Commission's next meeting.

Please feel free to contact me with any questions or suggestions, or if you should wish to attend any of the future stakeholder meetings.

Commonwealth of Massachusetts

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services

Recommendations of the Special Commission on Provider Price Reform

Appendix F

November 9, 2011

Áron Boros, Co-Chair
Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
Secretary
Executive Office of Administration and Finance

Appendix F:Votes of the Special Commission on Provider Price Reform on Wednesday, November 9, 2011

1. Voted unanimously to accept the report, excluding the recommendations, which were voted on separately.

Votes on Recommendations

2. **Recommendation 1**: Act upon the recommendations of the Special Commission on the Health Care Payment System to change the way we pay for and deliver health care services to improve the quality of care and reduce costs.
   - Voted unanimously to accept this recommendation

3. **Recommendation 2**: Increase transparency related to price variation.
   - Voted unanimously to accept this recommendation

4. **Recommendation 3**: Ensure competitive market behavior.
   - Voted unanimously to accept this recommendation

5. **Recommendation 4:** Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions.
   - Voted unanimously to accept this recommendation

6. **Recommendation 5**: Research acceptable and unacceptable factors for variation and then determine how they could be applied to reduce unacceptable variation in provider prices.
   - Voted unanimously to accept this recommendation

7. **Recommendation 6:** Establish a short- term process to ensure that higher prices may closely correlate to quality and thereby reduce costs.
   - Yeas: Secretary Jay Gonzalez, Commisisoner Áron Boros, Dolores Mitchell, Senator Richard Moore, Representative Steven Walsh, Amitabh Chandra, Patrick Gilligan, Dr. H. Eugene Lindsey, and Eric Linzer
   - Nay: Lynn Nicholas

DIVISION OF
Health Care
Finance and Policy

Division of Health Care Finance and Policy
Two Boylston Street
Boston, Massachusetts 02116

Phone: (617) 988-3100
Fax: (617) 727-7662

Website: www.mass.gov/dhcfp

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